Chapter 19
Communicating Bad News in the Health Care Organization

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The most important thing about communication is hearing what is not being said
—Peter Drucker

Abstract Communication is the dynamic exchange of information or news either verbally or non-verbally, which can have a profound emotional impact on both the receiver and the deliverer of news, especially if bad news is delivered badly. In the health care industry, communication occurs daily between medical and non-medical staff working to provide efficient and compassionate patient care. Despite the constant need for physicians and other health care professionals to communicate bad news to patients, there is poor emphasis on formal training in effective communication in the training curriculum. There is also a paucity of evidence-based literature on how to have difficult conversations in the work place or how to break bad news to a patient. This chapter reviews a multi-faceted approach to effective communication, and proposes helpful, practical strategies to effective communication in the workplace and during patient care. Efficient communication requires adequate preparation, true self-knowledge and responsibility, consideration and good listening skills from both parties, genuine display of empathy and compassion, conveying positive, hopeful messages during the conversation, individualized information to the specific situation and person, appropriate control of emotions, and efficient plans for support and follow-up after the conversation.

Keywords Bad News · Communication · Compassion · Conflict management · Difficult conversations · Disclosure · Ethics · End of life · Formal communication training · Individualized disclosure · Hope · Healing · Health care organization · Managing oneself · Medical communication · Non-verbal communication · Palliative care · Physician-patient communication · Verbal communication · Words

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Key Messages

- Effective verbal and non-verbal communication is a vital part of daily interactions in the health care industry between medical, non-medical staff and patients.
- Delivery of bad news should be hopeful, positive and compassionate and individualized based on each unique circumstance and need.
- Bad news delivered ineffectively has profound and long-lasting negative effects on both the deliverer and receiver of bad news.
- Bad news can be communicated peacefully and effectively with specific considerations before, during and after delivery using the "PEACES" technique: (Preparation, Environment, Audience, Compassionate Conversation, Emotional Expression, and Support).
- Effective communication of bad news is a skill that can be learned through disciplined self-knowledge, structured practice, and non-judgmental evaluation.

History and Principles of Communication

Communication is defined as "eliciting", "imparting" or "making known information [1]. Bad news is defined as any information that elicits an undesirable negative emotion from the receiver and may also cause anxiety to the deliverer.

There is power in the use of "words" in communication. The "word" is a basic form of communication, yet is universally and historically viewed as omnipotent, dynamic, and even divine. In the biblical account of creation, life came to being from the power of words, when God said into the void, "Let there be light!" [2]— words that immediately replace the "formless void" with structure, banishing the deep darkness, and there was light [3]. Words can result in peace or strife. The Quran says *"... when you speak, observe justice"* [4]. The Bhagavad Gita, the 700–verse Hindu scripture of philosophical conversations proclaims peace and hope [5]. Words once spoken cannot be recalled, thus their potential for good or for evil is formidable, and uttered words take on a life and power of their own, in themselves and over all else [3].

Communicating Bad News in the Healthcare Setting

Life in organizations is punctuated by bad news [6]. The health care industry is the bee hive of challenging day to day communications between medical and non-medical professionals with diverse interpersonal skills working towards a common goal—delivery of efficient and compassionate patient care. Like in all organizations, bad news in health care includes negative performance feedback, [7] customer service failures, [8] refusal of requests, [9] downsizing, [10] employee layoffs or termination, [11] frequent errors in communications, and systems failure affect global functioning. Effective communication is a necessary core value for health

care professionals [12]. Conflicts arise in organizational relationships when expectations are not aligned, and people expect others to be mind-readers.

Communicating Bad News

Communication involves the exchange of verbal and nonverbal messages between individuals. Verbal communication includes traditional face to face meetings, and the new age modes of electronic communication like phone calls, video conferencing, teleconferencing, and voice mails. Non-verbal communication includes emails, instant messaging, blogs, text messages, and the traditional letter writing or memos. Sussman and Sproul in their study comparing modes of news delivery noted that participants were more honest, accurate and satisfied when delivering bad news using computer-mediated communication than telephone or face-to-face communication [13]. Barriers to proper communication include inadequate communication skills, conflicting assumptions, different interpretations of the meanings of words (semantics), emotions, poor listening habits, insufficient feedback, and different interpretations of nonverbal cues [14]. The greatest inhibition to effective communication is one's ego.

Tips (Before Communicating Bad News)

- **Prepare yourself:** Gather your facts and information through objective and reliable means, and know the nature or demeanor of the person you will be communicating with.
- **Prepare the other party:** Psychological preparation or advance warning increases a sense of predictability of the bad news, [6] and can help individuals cope with negative emotions due to the impending bad news [15].
- **Build a relationship:** Trust and respect between the deliverer and the receiver of bad news reduces anxiety for both parties. If there is no prior relationship, the deliverer has to build this relationship early in the conversation.

Tips (During Communication of Bad News)

- **Location and Audience:** A serene and private ambience sets the tone of the conversation. Determine the appropriate audience for the conversation, whether private or key persons involved in case.
- **Have a true conversation:** A true conversation is not monotonous but solicits input or feedback from the receiver. A neutral or light opening statement may help break the ice. Non-verbal cues like posture, demeanor, eye contact, facial expressions, and body language may be more important than verbal cues. Use clear, precise and simplified term, and pause at serious junctures to enable the listener assimilate the news. Steven Covey, the management expert in his seven habits proposes that one should "begin with the end in mind," by determining what the desired outcome would be prior to having a difficult conversation [16].
- **Be simple and sensitive:** Communication should be polite, simple and to the point. Sensitivity to cultural, religious, language or socio-economic differences is crucial.

- **One minute rule:** Wait a minute before sending emotional or angry communication; which though valid at the moment to the sender, may be inappropriate when clarity is attained.
- **Always maintain a positive outlook:** This reduces the trauma of the news and helps the listener accept the news with hope. Use, what I call the "good 3A's" technique in breaking bad news: Acknowledge, Apologize, and Advise. Do not use the "bad 3A's": Avoid, Admonish, Attack.
- **Keep a record or document serious conversations:** Managers create a "paper trail" in the form of reports and documents, [17] As objective evidence about a situation that may lead to bad news [18, 19]. In the clinical setting, medical record documentation helps to keep the medical team abreast of care plans.

Tips (After Communicating Bad News)

- **Be a good listener:** Stone et al notes that difficulty listening during a conversation is from people mentally trying to decipher what really happened, how they or the other party is feeling, and wondering about their identity or what the others are saying about them [20]? Management expert and philosopher, Peter Drucker, famously said "the most important thing about communication is hearing what is not being said" [14].
- **Be prepared for emotions:** Despite a myriad of emotions expressed by the receiver of bad news, such as shock, fear, anger, denial, tears, silence, frustration, apathy or unexpected joy, the deliverer's daunting task is to maintain composure and empathy in validation of the receiver's feelings.
- **Show support and follow-up appropriately:** Respectfully find out the receiver's understanding of what was discussed and present any options to help them adjust to the new situation or move on from it.

Difficult Conversations in the Work Place

- **Use positive messages or statements:** People in management positions have the unpleasant tasks of giving performance evaluations and conveying news of inadequacy or unmet expectations to their sub-ordinates. Employing sensitivity and tact in difficult conversations yields positive reinforcement and mitigates the negative effect of the bad news.
- **Avoid premature judgments:** Premature punitive decisions based on unsubstantiated allegations are a common error in judgment by supervisors when evaluating colleagues, employees, or trainees. A supervisor should not join the bandwagon to admonish or reprimand employees, but rather serve as mediator to enhance understanding, encourage dialogue or reduce conflict. Evaluations should be based on objective evidence and not merely subjective reports. To avoid perception of personal bias, knowledge of personal crisis in an employee's life should never be used in a punitive way. Offer support to staff transitioning back to work. Address any valid concerns gently with the employee, giving suggestions for improvement before re-evaluating.

- **Manage conflicts appropriately:** Conflict management is important for effective functioning of an organization. Address conflicts at the appropriate level first. Escalating conflicts to higher management prematurely may make issues more difficult to control or resolve, [15] or create a hostile work environment. Five popular management strategies are competition, accommodation, avoidance, compromise and collaboration [16]. Competition entails overpowering the opposition during conflict of values or perspectives. Accommodation maintains a good working relationship by validating others' concerns. Avoidance evades conflict in matters of non-urgent importance. Compromise occurs when parties find a mutually acceptable solution is ideal. Fisher and Ury use "principled negotiation" tactic in conflict management, which involves looking for mutual gains when interests conflict based on fair standards [17]. There are two sides to every story, so seek to understand the other person's perspective and acknowledge their feelings before delivering your bad news.
- **Manage yourself:** Self-evaluation and feedback are keys to effective communication. Ericsson illustrates that becoming a good communicator can be learned with commitment and deliberate practice [18]. The sense of responsibility and feedback assessment that comes with managing oneself is vital to personal success and working well in an organization [19]. This feedback process begins with a deeper self-knowledge, and is so elaborately simplified by St. Ignatius of Loyola in his famous contemplative meditations "***Spiritual Exercises***" written in the fifteenth century after a period of self-discovery, discipline, and discernment [20]. It is human nature to expect others to change, but in reality one can only control or change oneself, which can have a profound influence on others [21].
- **Know yourself:** Awareness of one's personality promotes self-evaluation leading to personal responsibility in communication. I have observed three personality types in communication: silent, aggressive or defensive (SAD) communicators. *Silent communicators* may be silent-avoiders who evade uncomfortable conversations; or silent-narcissistic, feeling that certain situations are not worth their time; or silent-proactive, good listeners who carefully analyze information before communicating effectively. *Aggressive communicators* use very intense verbal and nonverbal attitudes and are easily offended. Some people are silent avoiders to prevent tendencies toward aggressive or defensive communication. *Defensive communicators* may not initiate the communication but usually have a rebuttal that is ineffective and unpleasant, though well-intentioned.

Practical Reflections on Difficult Conversations in the Workplace

Reflection #1 The scenario that comes to my mind is a nurse manager that I had to let go due to downsizing and reorganizing of the leadership team. The decision was not easy; I needed to make a decision that was best for the entire division. The skill set needed for the new, larger role was more strategic and I felt the individual was

not a good match for that role. I acknowledged her abilities and leadership over the length of her career—giving examples where she shined as a leader. I apologized that I would have to be the person to change her life in a dramatic way, but restated why I needed to make a leadership change. I allowed her time to ask questions, which I answered honestly and gave her time with the HR representative who would discuss her severance options. **-Kathy Kostrivas, RNC, MBA, Asst. VP Women's Services, Meriter Hospital, Madison, WI.**

Reflection #2 Though difficult in large corporations, an employer vicariously stands in loco parentis vis a vis his employee. They are like one family. While I was the chairman of a corporation, an otherwise dutiful, hardworking and loyal employee suddenly starts missing work two or three times in a week and often comes late on other days or leaves early because of tiredness. He apparently had serious medical issues, and could not afford to lose his job with children to support, and a wife whose job could not sustain the family. His frequent absence was injurious to daily operations. As Chairman, I was constrained to invite the employee and his wife to my office for some discussions. After expressing my understanding of their challenges, I granted the employee fully paid leave until he resolved his medical problems with a promise he will be re-engaged when he recovers. They went home happy and relieved. Unfortunately the employee died within two months and the family was very grateful that the company gave him that consideration. **-Dr. S. Okechukwu Mezu, Imo State, Nigeria.**

Breaking Bad News to Patients and Their Families

Physician-Patient Communication: Bad news in clinical care is defined as "any news that drastically and negatively alters the patient's view or expectation of her or his future," [22, 23] or "news that results in a cognitive, behavioral, or emotional deficit in the person receiving the news that persists for some time after the news is received" [24]. Breaking bad news can be stressful and have a long-lasting impact on both the physician and the patient [1, 25]. Recipients remember for a long time details of the news they received, especially if delivered in an uncaring and insensitive manner; [26, 27] and physicians report anxiety for days after delivering bad news [25]. Thorne et al elaborately categorized communication mishaps between healthcare professionals and their patients into three categories, namely *occasional misses*, *systemic misunderstandings*, and *repeat offenders* [28]. **Occasional misses** are where the doctor, though well-meaning, is unable to effectively communicate news, but the patient is forgiving understanding human fallibility. **Systemic misunderstandings** occur when physicians are seen as aloof, brutally frank or emotionally distant, more concerned about liability and professionalism than empathy. **Repeat offenders** are physicians that totally lack insight or interest in proper communication, and seem unwilling or unable to convey basic courtesy, compassion, or respect [28].

Table 19.1 Evidence-based guidelines on how to break bad news

Ask-Tell-Ask Tool [33]	Involves asking what the patient understands (Ask) before telling the news (Tell) and then evaluating what the patient understood (Ask) from the information provided
ABCDE *mnemonic* [52]	Proposes *A*dvance preparation, *B*uild a therapeutic environment/ relationship, *C*ommunicate well, *D*eal with patient and family reactions, *E*ncourage and validate emotions
SPIKES *protocol* [53]	Considers "*S*etting," "*P*erception," "*I*nvitation," "*K*nowledge," "*E*xploration," and "*S*ummary/strategy" during delivering bad news to patients
Nondisclosure, Full Disclosure and Individualized Models [54]	*Nondisclosure* assumes the patient needs to be protected from bad news and physician decides what information to provide. *Full disclosure* upholding the patient's right to full information gives too much detail causing negative emotional experiences. *Individualized disclosure* model believes that people have different coping methods and desires for information and so tailors it to the patient's needs

Evidence-based Guidelines: Despite the increased interest in the physician-patient relationship, there remains a paucity of evidence-based guidelines in literature or a clear set of norms about the best way to break bad news—a few are listed in Table 19.1.

Individualize the Bad News: According to Hippocrates, when communicating, one should "*give necessary orders with cheerfulness and serenity, revealing nothing of the patient's future or present condition*" [29]. This norm has shifted historically in the physician-patient interaction to increased effort to open, honest and full disclosure. Some patients may not like full disclosure of their illness, and physicians are challenged with individualizing the bad news delivery based on the patients' needs and desires [30]. Though more time consuming, the individualized disclosure model is a more effective way of giving clinical information [31].

Hope and Healing In Medical Communication: Healing is making a patient feel better or helping them peacefully accept their diagnosis and prognosis through the preservation of hope and a positive outlook, no matter the gravity of the news. Healing is the wellness of not just the body, but the mind, attitudes and soul. Hope is the prerogative of every patient and should not be taken away [32]. Good communication is more than being a "warm and caring" physician, but the ability to effectively assess patient's understanding, elicit care values and preferences, and encourage participation [33]. Patients appreciate honesty, but also positive, supportive and hopeful statements not merely listing worst case scenarios [34]. Doctors by aligning themselves to their patients can learn to respect and respond to the patient's sense of hope, even though not fully sharing it [23]. "Nothing can be done" statements should be replaced with "everything will be done" attitudes by adopting a cultural shift away from singular, curative biomedicine to seeking resources that help patients embrace living "as well as you can for as long as you can" [35].

Full Disclosure is Vital in Medical Communication: Evading medical disclosure and shifting responsibility can foster negative feelings in patients or families. Saying "I'm sorry," is not an acceptance of guilt or responsibility—it is merely a sharing of empathy and validation of the suffering person's emotions. Hospitals have now established a risk management task force to investigate medical errors or mistakes, and make full disclosure to the families, which has improved accountability of medical staff, patient satisfaction, and reduced medico-legal liability.

Practical Reflections on Breaking Bad News in a Clinical Setting

Reflection # 1 When breaking bad news to a patient, it is important to strike the right balance between providing information and overwhelming a patient with details, by tailoring information to the individual situation. Physicians sometimes feel an obligation to complete a predetermined script and mentally check off boxes as each piece of information is provided. This can leave patients feeling overwhelmed and confused. It is important to realize that many details may need to be repeated later after the initial shock has worn off. The most important aspects of the initial encounter are to make sure the patient feels supported and that there's a clear plan and direction about what the immediate next steps will be, whether it is further testing, hospitalization, or other treatments and when the next contact with the provider will be. **-Amy L Fothergill, MD, Internal Medicine, Associated Physicians, Madison, WI.**

Reflection # 2 Historically, some medical professionals, especially doctors, are seen as aloof, abrupt and lacking empathy. Below are simple ways one can break bad news to patients:

- **Know your patient:** Know a little bit about your patient, especially if they need family around when receiving the news. When possible, break the news in private.
- Your **body language** speaks volumes before you break the news. Maintain a vibe that says, 'I am here for you'.
- **Maintain eye contact** while talking; and sit at the same level so as not to be formidable.
- **Breaking the news:** Be direct, but compassionate. You can say "we did everything we could", concerning loss of a patient. If a hospice patient, you can remind them that it was a peaceful death.
- **Absorption:** Give patients a few moments to understand and assimilate what you have just said.
- **Scientific data:** Some patients would like to see proof of illness—lab results, imaging studies, or treatment options. You could say that "This is obviously a lot to take in now, but I would like you to know that there are some options that we can talk about…" You could have a specialist to provide more information or invite the patient to get a second opinion, if doubtful.

- **Knick Knack:** Have tissue ready at all times. Be calm and collected, enunciate properly, and speak slowly. Always know where the exit is—although this has not been my experience, some patients have been known to be violent, so know when to go for help. **-Ngozi Mezu-Patel, MD Infectious Diseases, Kent General Hospital, Dover, Delaware.**

Reflection 3 It is easy to tell your patients that you see their perspective, but going through the motions of having heard yourself what you have just told them can really open your eyes. It was not until I tried to schedule my life as a dialysis patient that I realized what I had been telling my patients. To integrate 4 hour treatments three times a week opened my eyes to the independence, travel, work, privacy and freedom that were at stake. I now ask my patients about the rest of their lives and what is most important for them. This lets them know that they are seen as more than a disease, and that we are working with them to make their lives work, not just their kidneys. **-R. Allan Jhagroo MD, Division of Nephrology, University of Wisconsin, Madison.**

Communicating News About Serious Illness, End of Life or Palliative Care

Respect Spirituality in End of Life Communication: Death comes to all, yet the fore-warning in medical illness does not seem to allay the fear, shock or uncertainties about prognosis, extent of suffering, and end of life decisions. The best antidote for patients' uncertainties is effective communication [36]. Discussing death may be difficult for physicians due to a sense of personal failure, fear of how the family will react, or personal insecurities about mortality. For clinicians to be thorough and compassionate, their care must extend beyond the physical realm to the spiritual [37, 38]. Some patients want to discuss beliefs about the soul after death with their health care providers [39, 40]. Always offer patients spiritual care according to their religious affiliation, [41] as spiritual beliefs vary with each religious sect. Regardless of religious inclinations or lack thereof, there is a universal belief in love and compassion shared by all human beings, especially when in need of healing of physical or emotional pain.

To Speak or Not to Speak: Sometimes, words are unnecessary in times of grief or delivery of bad news; and a presence, quiet empathy, tears, touch or a hug is equally effective. People express grief in various ways, like apathy, anger, denial, sadness, or a smile. This individual right of expression should be respected, not judged. Understanding and compassion is all patients and families need from their health care providers.

Withdrawal of Life Support is Not a Withdrawal of Care: It can be extremely difficult for families of patients in the intensive care unit (ICU) to cope emotionally as they transition from thinking there may be a cure to, the next time, facing palliative care or imminent death [36, 42]. Although a physician has no obligation to

provide futile care, patient care continues compassionately through helping the family cope with the loss. "*Do not resuscitate orders*" must be clear and unambiguous. Withdrawal life support should be done after open and honest discussions with the family and medical team. Health care professionals should provide the highest quality of terminal and palliative care for dying babies just as in adults [43]. Respecting families' end of life wishes, allowing them at the bedside during terminal procedures, providing time to gather other loved ones for support, and compassionate care of the patient and family help bring closure, peace and acceptance to the grieving family, and reassure them that "everything was done".

Ethics of Communication in Perinatal and Neonatal Care: With advances in neonatal and obstetric care, premature infants are surviving at younger gestational ages, bringing a unique set of clinical, moral and ethical challenges. Extremely premature infants have severe neurodevelopmental disability, [44] including cognitive deficits, hearing loss, cerebral palsy, and blindness that can affect them up to adolescence [45] and beyond. The ethical principles of autonomy, beneficence, non-maleficence, and justice, [46] apply to fetuses or infants facing a life-limiting diagnosis as well as their mothers. Caring for infants in neonatal intensive care units requires extraordinary sensitivity, extreme responsibility, and heroic compassion [47]. Physicians should present facts in an honest and unbiased way, avoiding grossly grim or falsely optimistic information. Find out what the family knows, before giving information in simple language devoid of excessive medical jargon, remaining supportive of the family's decision. Parents and medical staff are both advocates in considering the 'best interest' of the child. In complex ethical situations or when conflicts arise between parents' and physicians' desires for the child, a referral should be made to the hospital ethics committee for a formal consensus. Good palliative care entails a systematic multidisciplinary coordination of services to avoid communication breakdowns, [48–50] provide direction for clinicians and appropriate follow-up [51].

-Practical Reflections on Breaking Bad News in Special Situations

Reflection # 1 In a difficult conversation, like when asked by the obstetrics team to counsel a mother at high risk of delivering a premature infant, I first try to understand the medical situation and concerns from the referring physician and the mother's nurse. With the mother, I identify myself and my first question is, "what is your understanding of how things are going?" If there's a good understanding, I focus on high risk areas, clarify the baby's needs, provide relevant statistics on outcomes, and answer any specific questions. When providing information, I try to comment on the likelihood of survival, which is where the greatest fear lies—will my baby survive? If this fear can be allayed, then she more likely will remember the rest of the conversation. I find out if she knows whether the baby is a boy or a girl and the

baby's name, as I want our discussion to be about an individual, not simply statistics. I like to end the conversation by asking if she plans to breast feed, giving her the responsibility of asking the nurses for help with pumping after birth. This gives her some control, reinforcing my perspectives of a longer term outcome, and let her know this is something important that only she alone can do to help her baby. **-De-Ann M. Pillers, MD, PhD, Professor and Chief of Neonatology, Department of Pediatrics, University of Wisconsin-Madison.**

Reflection # 2 There is no one good way of breaking bad news to a patient. What is important is the physician-patient relationship. A long term relationship does not necessarily make it easier to speak the bad news, but adds a different atmosphere to the room. At the moment of delivering the news, it is important that the physician stay with the patient and not run off or send in a chaplain. It also helps if family members are present when the news is delivered, in recognition that the news is not just for the individual, but is a family affair. Obviously, there are several levels of bad news and not everything needs to be stated at once. We have to face ourselves as well when we deliver bad news to others. A patient by definition is one who suffers and waits. It is our task to suffer and wait with them in a vicarious and empathic manner. **-Anthony O'Connell, Psy.D., Dip. Psa, Licensed Clinical Psychologist, Chicago, IL.**

Reflection # 3 To the deliverer of bad news, it can be an emotional, regrettable and overwhelming experience. To the recipient, that moment, whether absorbed with a calm, stoic demeanor, uncontrollable tears or more dramatic gestures, changes their life forever. I am very aware of that moment which is irreplaceable. They typically can sense the doom that looms ahead but harbor a slight hope that there might be an alternative. I usually have the loved ones meet in a quiet room, and pastoral services available if needed. I always ask if someone can be with them as bad news can sometimes be better braced by two or more rather than one. "I am so sorry to have to tell you…" I let them know that they did not suffer as that is very comforting to loved ones. I inform them that we did all we could, and I offer a hand, a shoulder, or a hug—whatever they may need. It is a difficult and heart breaking time for both ends, but their journey ahead can only be tougher than mine. **-Ure L. Mezu-Chukwu, MD, Cardiology-Electrophysiology, Georgia.**

Summary

Effective communication using hopeful, positive and compassionate methods is vital to the overall success of the hospital organization. Bad news can be communicated with the **"PEACES" (Preparation, Environment, Audience, Compassionate Conversation, Emotional Expression, and Support)** technique that incorporates effective skills and attitudes, which I believe, emphasizes the hopeful peace both parties should feel after the effective communication, rather than the dreaded pieces of hopelessness after poor communication (Table 19.2).

Table 19.2 Delivering bad news in peaces

Preparation	Advance preparation for both the deliverer and the receiver of bad news is crucial
Environment	Deliver news in quiet, private, and peaceful environment
Audience	Have the appropriate audience for the news.
Compassion	Ensure a compassionate conversation with good listening skills, empathy
Expression	Anticipate and respect expression of emotions from receiver
Support	Indicate and show your support and willingness to follow-up

The art of proper communication, like any craft, requires skills acquisition and training by observing, practicing, sometimes failing and re-learning till mastered, and evaluation of the completed task. Everyone in their lifetime has the privilege of wearing two hats: one of authority in delivering bad news and the other of dependence in receiving bad news. An emotion common to both parties is HOPE—hope for empathy, respect, understanding, acceptance, and a non-judgmental attitude; yet, deliverers of bad news tend to forget the feelings of dependence of being receivers of bad news. A peaceful communication should always be the goal when delivering news, because bad news delivered peacefully reduces the likelihood that bad news will be received badly.

References

1. Dias L, Chabner BA, Lynch TJ Jr, Penson RT (2003) Breaking bad news: a patient's perspective. Oncologist 8:587–596
2. The Bible (1982) The Holy Bible—New King James Version. Thomas Nelson, Nashville
3. Mezu RU (2004) The power of the word (Nommo) in social change in homage to my people. Black Academy, Pikesville, MD: 128–48.
4. Quran T (2012) The Quran. IB publisher, Hicksville
5. Zaehner RC (1996) Hindu scriptures. Goddall, D (Ed). University of California Press, CA.
6. Bies R (2013) Delivery of bad news in organizations: a framework for analysis. J Manage 39:136–162
7. Ilgen D, Davis C (2000) Bearing bad news: reactions to negative performance feedback. Appl Psychology 49:550–565
8. Michel S, Bowen D, Johnston R (2009) Why service recovery fails: tensions among customer, employee, and process perspectives. J Ser Manage 20:253–273
9. Izraeli DM, Jick TD (1986) The art of saying no: linking power to culture. Organ Stud 7:171–192
10. Cascio WF (1993) Downsizing: what do we know? What have we learned? Acad Manage Exec 7:95–104
11. Bennett N, Martin, CL, Bies RJ, Brockner J (1995) Coping with a layoff: a longitudinal study of victims. J Manage 21:1025−1040
12. Schofield NG, Creed F (2008) Communication skills of health-care professionals working in oncology: can they be improved? Eur J Oncol Nurs 12:4–13
13. Sussman SW, Sproull L (1999) Straight talk: delivering bad news through electronic communication. Inf Syst Res 10:150–166
14. Drucker PF (1993) Communication skills: "The most important thing in communication is hearing what isn't said." Management Now 24–47.
15. Lemieux-Charles L (1994) Physicians in healthcare management: managing conflict through negotiation. Can Med J 151:1129–1132
16. Thomas KW (1976) Conflict and conflict management. In: Dunnette MD (ed) Handbook of industrial and organizational psychology. Rand McNally, Chicago, pp 889–935
17. Fisher R, Ury W (1981) Getting to yes: negotiating agreement without giving, 1st ed. Penguin Books, New York.
18. Ericsson K, Anders P, Michael J et al (July-August 2007) The making of an expert. Harv Bus Rev 115–121.
19. Drucker P (2005) Managing oneself (HBR classic). Harva Bus Rev.
20. Ignatius St (2002) The spiritual exercises of St. Ignatious of Loyola. Random House, Toronto
21. Thornby D (2006) Beginning the journey to skilled communication. AACN Adv Crit Care 17:266–271
22. Buckman R (1984) Breaking bad news: why is it still so difficult?. BMJ (Clin Res Ed) 288:1597–1599.
23. Back AL, Arnold RM, Tulsky JA, Baile WF, Fryer-Edwards KA (2003) Teaching communication skills to medical oncology fellows. J Clin Oncol 21:2433–2436
24. Ptacek JT, Eberhardt TL (1996) Breaking bad news. A review of the literature. JAMA 276:496–502
25. Ptacek JT, Ptacek JJ, Ellison NM (2001) "I'm sorry to tell you…" physicians' reports of breaking bad news. J Behav Med 24:205–217
26. Maguire P (1998) Breaking bad news. Eur J Surg Oncol 24:188–191
27. Fallowfield L (1993) Giving sad and bad news. The Lancet 341:476–478
28. Thorne S, Oliffe JL, Stajduhar KI, Valerie Oglov BSW, Kim-Sing C, Hislop TG (2013) Poor communication in cancer care. Cancer Nurs 36:445
29. Hippocrates. Decorum X (1923) Hippocrates with an English translation. Heinemann, London

30. VandeKieft GK (2001) Breaking bad news. Am Fam Physician 64:1975–1978
31. Girgis A, Sanson-Fisher RW (1995) Breaking bad news: consensus guidelines for medical practitioners. J Clin Oncol 13:2449–2456
32. Mezu-Ndubuisi O. (2009) Tips for parents to help survive the journey before, during and after the NICU and improve interaction with NICU staff. http://wwwobiolarosefoundationorg/nicu-survival-tips-for-parents/. Accessed 3 Feb 2014
33. Schell JO, Arnold RM (2012) NephroTalk: communication tools to enhance patient-centered care. Semin Dial 25:611–616
34. Informing Families Project (2007) Informing families of their child's disability. http://wwwinformingfamiliesie/evidence-based-good-practice/sensitive-and-empathetic-communication252html. Accessed 3 Feb 2014
35. Kagan SH (2009) Nothing can be done-a reply to thoughtless prognostic declarations. Geriartr Nurs 30:424–425
36. Kirchhoff KT, Walker L, Hutton A, Spuhler V, Cole BV, Clemmer T (2002) The vortex: families' experiences with death in the intensive care unit. Am J Crit Care 11:200–209
37. Perkins HS, Cortez JD, Hazuda HP (2012) Diversity of patients' beliefs about the soul after death and their importance in end-of-life care. South Med J 105:266–272
38. Daaleman TP, VandeCreek L (2000) Placing religion and spirituality in end-of-life care. JAMA 284:2514–2517
39. Anandarajah G, Hight E (2001) Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. Am Fam Physician 63:81–89
40. Balboni TA, Vanderwerker LC, Block SD et al (2007) Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. J Clin Oncol 25:555–560
41. Barnes S, Gardiner C, Gott M et al (2012) Enhancing patient-professional communication about end-of-life issues in life-limiting conditions: a critical review of the literature. J Pain Symptom Manage 44(6):866–879
42. McAdam JL, Puntillo K (2009) Symptoms experienced by family members of patients in intensive care units. Am J Crit Care 18:200–209; quiz 10
43. Wyatt J (2004) Neonatal ethics. CMF files 27.
44. Tyson JE, Parikh NA, Langer J, Green C, Higgins RD (2008) Intensive care for extreme prematurity-moving beyond gestational age. N Engl J Med 358:1672–1681
45. Hack M, Fanaroff AA (2000) Outcomes of children of extremely low birthweight and gestational age in the 1990s. Semin Neonatol 5:89–106
46. Purdy IB, Wadhwani RT (2006) Embracing bioethics in neonatal intensive care, part II: case histories in neonatal ethics. Neonatal Netw 25:43–53
47. Wanzer S, Federman DD, Adelstein SJ et al (1989) The physician's responsibility towards hopelessly ill patients. N Engl J Med 320:844–849
48. Wool C (2013) State of the science on perinatal palliative care. J Obstet Gynecol Neonatal Nurs 42:372–382
49. Chitty LS, Barnes CA, Berry C (1996) Continuing with pregnancy after a diagnosis of lethal abnormality: experience of five couples and recommendations for management. BMJ 313:478–480
50. Miquel-Verges F, Woods SL, Aucott SW, Boss RD, Sulpar LJ, Donohue PK (2009) Prenatal consultation with a neonatologist for congenital anomalies: parental perceptions. Pediatrics 124:e573–e579
51. Côté-Arsenault D, Denney-Koelsch E (2011) 'My baby is a person': parents' experiences with life-threatening prenatal diagnosis. J Palliat Med 13:1–7
52. Rabow M, McPhee SJ (1999) Beyond breaking bad news: how to help patients who suffer. West J Med 171:260–263
53. Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP (2000) SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. Oncologist 5:302–311
54. Donovan K (1990) Breaking bad news. In: Sanson-Fisher R, ed. Interactional skills: doctor/patient relationship. University of New Castle, Newcastle