

Research papers

Developing an audit instrument for breaking bad news

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ABSTRACT

This short discussion paper considers the nature and setting of the breaking bad news consultation, and the issues involved in conducting audit in this area. It offers a brief review of some of the limited published work available on this relatively overlooked topic, and sets out the approach under-

taken locally to develop an audit instrument focusing on one aspect of the process: documentation of the initial consultation.

Keywords: audit, breaking bad news, consultation, documentation

Breaking bad news is an important and often difficult task faced by nearly all health professionals, although most often responsibility for the initial consultation lies with the doctor responsible for the patient's care at that time, and this is a role expected by patients.¹

There has been increasing research into the impact of bad news breaking on patients and its effect on their psychological adjustment and their perceptions of the doctors involved.^{2,3} Studies have also considered the stress this task causes doctors.^{4,5} In addition, there are numerous reports of educational interventions for healthcare professionals, although only a minority of these have been fully evaluated.⁶⁻⁹

However, much of the research has focused on clinicians working in secondary care. Within primary care, the nature and range of breaking bad news consultations is going to be far more variable for the individual clinician. For example, while confirmation of a cancer diagnosis is likely to be given by a hospital specialist,³ initial suspicions are likely to be discussed by the general practitioner (GP) prior to referral for further investigations. In the context of a condition such as diabetes mellitus, both diagnosis and follow up are most likely to take place in the primary care

setting. A key difference between primary and secondary care is that the breaking bad news consultation is likely to be part of an evolving process that builds on a pre-existing relationship. This has both up and down sides: communication is likely to be easier where the patient and health professional know each other. However, the open access to a surgery appointment means that the clinician has little time to prepare, and may uncover a 'bad news' diagnosis during a routine consultation, e.g. the six-week check on a new-born that reveals a previously unsuspected cardiac anomaly.

While there are a wide variety of texts that include pointers on 'how to do it', there are very little published data on policies or auditing the process of bad news breaking. Thus for hospitals or primary care trusts there is a tendency to reinvent the wheel whenever the question of guidelines arises in this area.

One of the issues is determining what to audit, as the breaking bad news process can be viewed in a number of stages:

- system factors, e.g. the arrangements of appointments to make it feasible for individuals to be

scheduled specifically for a breaking bad news consultation, and the availability of privacy

- the organisation of team roles, e.g. the availability of a clinical nurse specialist either for a first consultation or to provide follow-up information
- the performance of the individual clinician
- documentation and ongoing communication between members of the secondary care team and the primary care team.

One of the very few attempts to set out process guidelines that might be auditable was by a group reporting to the King's Fund.¹⁰ They set up a multi-disciplinary joint working group: doctors (surgeons, oncologists and a GP), specialist nurse, counsellor and four patient representatives (including one with experience as a carer). Facilitated by an independent professional, they met with a structured remit and fixed time frame to come up with a series of guidelines, focusing on the outpatient setting. These covered both system factors (availability of notes and test results, diversion of telephone calls) and individual performance. They also touched on follow up processes (see Box 1). The joint working group

also suggested complementary interventions to supplement the process:

- referral form for GPs to communicate relevant information about and to the patient
- form to be sent to the patient's GP giving details of the bad news interview.

Following the recommendations of the original group, the guidelines were piloted and audited.

As the authors point out, these guidelines were intended for use when the first diagnosis of cancer was given, and applied largely to the hospital outpatient environment.

In our local acute hospital trust and cancer centre, the lead cancer clinician produced a consensus guideline document representing cancer clinicians (see Box 2).¹¹ This applied to a wider setting, although still focused on secondary care. It also did not include an explicit user viewpoint.

In comparing the two sets of guidelines, there appeared to be agreement on all major points, although there were different points of emphasis. The trust guidelines considered the process for breaking

Box 1 Summary of King's Fund guidelines¹⁰

- **Referral:** from GP to the specialist should include information about the patient, and the GP should explain to the patient what to expect.
- **Prior to consultation:** the *specialist* requires a precise diagnosis where possible, a family history, and knowledge of the patient's understanding of their disease. Preparation time is also required.
- **Prior to the consultation:** the *patient* requires waiting times in clinics to be minimised, and to be told that they can bring a friend or relative.
- **During the consultation:** the *specialist* requires a quiet, private and uninterrupted environment, a support nurse, time, and the patient in as good a condition to receive the news as possible, e.g. sitting up and dressed.
- **During the consultation:** the *patient* requires the doctor to introduce him/herself and the support nurse, address them by their name, make eye contact, and give a message of hope.
- **Throughout the interview:** the specialist should check that the patient understands, and by the end of the interview the patient should have as clear an idea as possible of what the diagnosis is. Information given about future treatment should be explained, including the physical sensations to be expected. Personalised written information should be given which includes:
 - the name of the specialist and support nurse and contact details
 - where to get further support and information
 - the date of the next appointment.
 A general information leaflet about the condition should also be given.
- **After the consultation:** the *specialist* should ensure that a support nurse is available and that appropriate arrangements have been made for returning home, follow-up support, tests, appointments and the needs of relatives.
- **After the consultation:** the *specialist* should send information to the GP which includes the name of the support nurse, what was said in the consultation and how it was received.

Box 2 Summary of Walsgrave (now UHCW) Trust guidelines¹**Process**

What should the patient be told?

Guideline

- Use an open explanation with clear non-euphemistic language: diagnosis, treatment plan and options, complications of treatment, follow-up arrangements, effects on lifestyle, prognosis (as known).
- Be sensitive to: patient's ability to comprehend, need to know, mental state. This may require a progressive approach with or without written materials or tape recording of consultation.
- For patients indicating a wish not to know, the clinician should ask permission to inform relatives.

Who should tell the patient?

- A senior member of the medical team. Junior doctors and nurses should be present to ensure the rest of the team is aware of what has been discussed and as a component of their training.
- Where the patient addresses questions to a junior member of team, the response should be within the limits of that individual's knowledge, and then referred back to senior member.

Environment

- Should be quiet and private.
- Patient should be offered the option of having a friend or relative present.

How should the consultation be recorded?

- The doctor giving information should document what the patient has been told, with a parallel note being made in Nursing Kardex by the senior nurse present at consultation, to ensure other team members are aware of the situation explained to patient.
- Records should be updated as circumstances change.

What should the relatives be told?

- Information about the patient's disease is confidential between the patient and doctor; it should not be discussed with relatives without prior agreement of patient unless the physical or mental state of the patient makes agreement impossible.
- The doctor talking to relatives should be the one who disclosed information to the patient, and relatives should preferably be informed in the presence of the patient.

How should carers outside the hospital environment be informed of what the patient has been told?

- The patient's consultant or senior deputy should inform the GP by letter, or sometimes initially by telephone, of the clinical situation and precisely what the patient and relatives have been told.
- The consultant or senior deputy should also ensure that Macmillan team or community link nurse are informed in writing where their involvement is appropriate.

bad news throughout the hospital setting, rather than only in the clinic. Both considered that the most appropriate person to break bad news is the senior clinician involved in the diagnostic process, consistent with patient survey results.¹ However, trust guidelines also acknowledged issues such as junior staff involvement, and the need sometimes to stage the

breaking bad news process as more information emerges or as the patient's wish for information dictates.

As a member of the palliative care team working both in the hospital and community setting, I observed that within the hospital we were often 'picking up the pieces' emotionally after unsatisfactory

consultations. Meanwhile, within the community there was a sense of isolation, with primary care teams unaware of what had taken place. Thus, we decided to combine elements from the King's Fund and our own trust guidelines, to audit both documentation and a subsequent examination of practice and patient experience.

First we audited case notes ($n = 95$), for which we used a 17-point proforma based on a combination of the two sets of process guidelines. This explicitly included points that might be recorded as opposed to observed (e.g. the name and professional identification of the person breaking bad news; the presence of specified team members). While it was anticipated that some of the points might be too detailed for inclusion in every interview, all were felt to have validity. The subsequent analysis showed that documentation was highly inconsistent, and less than half of the 17 points on the proforma were documented regularly (see Table 1). Key points that were infrequently documented included terminology (i.e. what the patient had actually been told), which was only recorded in 31.6% (30/95), while the patient's level of understanding was documented in 16.8% (16/95). Who broke bad news was recorded in 67.4% of cases, but in only 42% of those was identification complete (i.e. legible recording of name, signature, professional role). Most disturbing in terms of interprofessional communication was the lack of information passed on to the GP: only 16.4% (12/73 patients who were discharged or seen as outpatients) received written details of what the patient had been told.¹²

We then conducted semi-structured interviews with 105 newly referred oncology patients. Full details of this exercise are still being analysed and will be presented in a further publication, but initial findings proved somewhat more reassuring: good practice guidelines appear to have been followed in most cases. Although documentation of areas such as patient understanding was poor in the preceding audit, the patient reports indicated that the majority did feel they understood the information given, and were able to ask questions. The only significant gaps were in pre-warning the patient to bring a companion if required, and providing contact numbers.¹³

However, while patient surveys provide a valid approach to examining the patient experience, they may not always reflect the objective behaviour of the health professional, which may require a separate observational exercise.¹⁴ This can involve placing an actual observer in the consultation, which is likely to prove practically difficult to achieve unless the observer is part of the regular team (as utilised in Walker's audit in 1996).¹⁰ This then risks introducing subjective bias, unless the rating criteria are very clearly specified, which may reduce the discriminatory power. Alternatively the consultation may be audio-

Table 1 Audit points used in proforma and frequency of documentation

Audit points	Frequency of documentation	
	Total recorded ($n = 95$)	Percentage recorded
Was news broken	65	68.4
Where the news was broken	22	23.2
Who broke the news	64	67.4
Terminology used	30	31.6
Patient's understanding	16	16.8
Patient's response	15	15.8
Other relatives informed	57	60.0
Who was present	25	26.3
Next plan of action	60	63.2
If contact number left with the patient	9	9.5
Other medical personnel informed	27	28.4
Who documented the breaking bad news interview	44	46.3
Treatment options discussed	42	44.2
Discussion about prognosis	23	24.2
Who instigated the interview	22	23.2
Patient requests noted	17	17.9
Patient suspicions of diagnosis	9	9.5

or video-recorded, which can subsequently be rated independently. This is not unfamiliar to GPs, as recording actual consultations has formed part of the assessment process for the Member of the Royal College of General Practitioners (MRCGP) examination since 1995.

There may be some practical constraints in recording breaking bad news consultations, although this

has been carried out successfully in the oncology outpatient setting.⁹ From the viewpoint of auditing clinician performance among those groups where breaking bad news is a less predictable element of their working day, a more standardised approach would be to use simulated consultations. While this produces a best behaviour on the part of the clinician, it is a fair way to evaluate differences in performance in a standardised context, either for examination or educational purposes.¹⁵ A simple rating schedule that we found useful was the BAS (Breaking bad news Assessment Schedule), developed in Oxford for undergraduate educational purposes, but which we have successfully applied to postgraduate assessment.¹⁶

It is unlikely that any one instrument could be designed to measure all these facets in all settings, but we have begun to identify key points that are amenable to measurement, and to develop or identify tools that may be used at each step. While it will always remain a challenging task, effective methods for assessing the quality of the process of breaking bad news will help health professionals to ensure that the patient experience is as satisfactory and causes as little trauma as possible.

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Accepted September 2003