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ETHICS CASE

Professionalism and Appropriate Expression of Empathy When Breaking Bad News

Commentary by Amy Blair, MD, and Katherine Wasson, PhD, MPH

Kelsey is a third-year medical student doing rounds in internal medicine. Yesterday, she met Ms. Foster, a quiet woman who was admitted due to a bad case of bronchitis. Kelsey was asked to help prep Ms. Foster for an x-ray. At first, Ms. Foster was a little standoffish and their interactions were awkward. Kelsey decided to try and make some small talk. Noticing a picture of a Great Dane as the backdrop on Ms. Foster's phone, she asked if it was a photo of her dog.

Ms. Foster smiled. "Yes. His name is Stormy," she said.

"I have a dog too—a pit mix named Finny," replied Kelsey.

With the ice broken, they began to talk more, and soon Ms. Foster mentioned that she had two sons, Andrew and Stu. Stu, the older, was nervous about starting high school. "I just hope I'm better by the end of the week so that I can be there when he comes home from his first day," Ms. Foster admitted nervously.

"We'll do all we can to help make that happen," Kelsey assured her. By the time Ms. Foster was ready for radiology, she seemed to be in a better mood, and she thanked Kelsey for talking with her.

The next day, Dr. Baum, the attending physician for Kelsey's internal medicine unit, approached Kelsey as she was prepping for rounds. "The x-ray of the 48-year-old woman with bronchitis showed some suspicious masses, so I sent the images to radiology for a second opinion, and they confirmed what I feared. There is a 5-centimeter mass in her right lung and two smaller masses in her left lung." Kelsey's heart dropped. She knew what this meant: late-stage lung cancer. "Of course, I will want to confirm with a CT scan and biopsy, but today we have the difficult task of informing Ms. Foster of what we suspect we have found and what the next steps are."

Feeling five times heavier than she had that morning, Kelsey followed Dr. Baum into Ms. Foster's room. There were fresh flowers on her nightstand with a note signed, "Your favorite boys." Ms. Foster lit up at the sight of a familiar face, and Kelsey felt that her heart might burst.

Dr. Baum took a seat beside the bed, and Kelsey followed. After the preliminary greeting, Dr. Baum gently cleared her throat and began, "I saw some suspicious masses on your x-

ray yesterday that could be cancerous." She paused a while before continuing, "I'd like to order a CT scan so that we can learn more."

Ms. Foster sat for a while in stunned silence and then began to cry. Tears ran down Kelsey's face as well, and, overcome with sympathy, she reached for Ms. Foster's hand and began to rub it gently with both of hers.

After answering Ms. Foster's questions, Dr. Baum and Kelsey left the room. As they walked down the hall together, Dr. Baum turned to Kelsey. "Kelsey, it's all right to feel sympathy for patients, but you crossed a line there. Crying can detract attention from the patient, and some patients do not like to be touched. It's natural to want to help patients, but you need to learn to channel that energy into being a good practitioner and leave the more personal comforting to family and friends." Then, more gently, she added, "It will get easier over time. As you see more and more, you won't feel the emotions as much."

Commentary

Breaking bad news empathically to patients requires recognizing signs and patterns from patient cues, and the set of potential responses is as broad as a good differential diagnosis. As a physician, you need to note the patient's affect as you walk in the room. Does her face indicate a sense of dread? Does he seem determined? Does her greeting indicate all is well and that the information you hold will be unexpected? These cues should guide your response. It may be best to present information bluntly to relieve the tension an anxious patient displays. Other times, taking a gentler approach is better. Moving tissues closer to the patient communicates that he or she may need to be prepared for bad news, that it is acceptable to show emotion, and that you as a physician are open to whatever response he or she might have. You should also be attuned to your own emotions and recognize the role emotion and empathy play in clinical practice.

In this case, Dr. Baum's belief that Kelsey is behaving inappropriately originates from concern for the patient. If Ms. Foster had been uncomfortable with Kelsey's tears, the focus in the room would have shifted from the patient to the medical student. Kelsey, on the other hand, formed her response based on extra time she had spent with Ms. Foster. Dr. Baum was not present during those interactions; she did not see the change in Ms. Foster's demeanor while Kelsey was prepping her for the x-ray. Kelsey found that Ms. Foster responded to a more personal approach, that engaging her about her dog and family helped her relax. Dr. Baum may have missed important clues to the ways Ms. Foster wanted and needed to hear bad news. So, perhaps Dr. Baum's impression is that Kelsey does not know Ms. Foster well enough and that Kelsey's reaction is self-centered and lacks self-control.

This situation occurs frequently in medical schools. How many times do physicians in training enter a room, especially that of a hospitalized patient, and know the patient's personal history in more detail than the rest of the team? Even with their clinical inexperience, medical students who spend more time talking with patients may have a better "feel" for a patient's personality and reactions than more experienced clinicians who have barely spoken with the patient.

Dr. Baum appears to believe there is a clear boundary between appropriate and inappropriate emotional responses that is the same with all patients. Crying in the room with patients could be intrusive, especially if it makes the patient feel worse. What if the patient thinks a physician's tears reflect hopelessness from a medical perspective or that the physician is overemotional, unprofessional, or imbalanced? These are all plausible interpretations of a physician's tears. Is it not best to avoid crying altogether?

Kelsey also chose to rub Ms. Foster's hand. Many physicians find touching a patient's hand or shoulder to be a natural response. "Clinical" touch is an expected part of the patient-physician relationship because of the physical exam, and patients usually trust physicians to use physical touch for diagnostic purposes. But the intimacy of rubbing Ms. Foster's hand may also jeopardize that trust. It is significantly more personal than the clinical touch, and it is plausible that Ms. Foster could interpret that action as intrusive. Whether because of experiences during training or her own emotional development, Dr. Baum may value emotional detachment. Learning and maintaining professional boundaries can easily turn into learning and maintaining detachment, which can be further rewarded when detachment is perceived to be synonymous with rationality and clinical objectivity. Additionally, there may be incentives for women to display detachment at all costs to combat the stereotype that they are excessively emotional.

Dr. Baum may also be making a genuine attempt to mentor Kelsey on emotional survival and navigating the range of emotions experienced during interactions with patients. Physicians can be witnesses to significant physical and emotional suffering and are vulnerable to their own intense emotions. The key is to acknowledge that emotions are a part of the profession and to understand and use the patterns in those emotional responses. Assessing your emotional reactions can prevent desensitization to patient relationships and even promote the joy of patient care that often draws physicians to the practice of medicine. Effective strategies for such assessment after intense patient encounters can include personal reflection, debriefing through talking with family or friends, or decompressing through hobbies or relaxation.

Dr. Baum attempts to prepare Kelsey by telling her that this will be a "difficult task," alluding to what must be previous experiences with delivering undesirable news to patients. Just as physicians build their clinical diagnosis skills based on prior patient presentations, so through interacting with patients they build a repertoire of communication strategies and emotional responses to patient cues, including reflective listening, pauses, or silence, as well as letting the patient know he or she is not alone ("I have another patient who had this diagnosis..."), humor, or encouragement. It is plausible that Dr. Baum developed the strategy of leaving the "personal comforting to family and friends" after difficult experiences in the delivery of bad news or seeing other physicians do so during her training, just as she applies prior clinical experience to current cases. Perhaps it is the feelings of loss after the death of a patient similar to Ms. Foster that are guiding her responses and views. Without strategies to process the losses that occur in patient care, Dr. Baum may have concluded over time, perhaps unconsciously, that it is better and less risky to try to keep empathy out of her relationships with patients.

Processing emotional loss requires a great deal of energy and time that, for many physicians, is not readily available. Residual woundedness left by unprocessed grief and other emotions can compound. To survive emotional injury, many physicians develop conscious or unconscious coping strategies—using a closed rather than open emotional approach to patients' responses, becoming less aware of the verbal or nonverbal cues that may indicate a patient desires a more personal approach, or shuffling the job of meeting patients' emotional needs to other members of the team or patients' families.

So, rather than being a cold, heartless teaching, Dr. Baum's admonition to Kelsey may reflect genuine concern: that if Kelsey cries with patients, Kelsey will suffer from emotional exhaustion, compassion fatigue, and possibly burnout. Her words for Kelsey are intended to help her "not feel the emotions as much." She could be trying to spare Kelsey the painful process she has experienced or seen others go through to try to manage the emotions involved in patient care.

The ideal way to respond to each patient's emotions is different and requires mindfulness and experience; this is especially challenging for students who desire a sense of the "right way" to provide good care. They often want a rubric or algorithm to guide their interactions and decisions that parallels the diagnosing of diseases. This is understandable, and we may be able to develop some best practices for expressing empathy and managing emotions with patients.

1. Be open to the unpredictable nature of human emotion. Expect emotions to be present in your interactions with patients and their families. Practice how to be more comfortable with patients' and your own emotions through methods such as role play with fellow medical students or debriefing with friends or family.
2. Meet the patient's emotional response in ways that still feel professional. Do not feel afraid of emotions expressed by patients; they are not requirements for reciprocal responses. If it is not natural to you to show emotions openly or use physical touch to communicate, it is important to find other ways to acknowledge that you are witnessing the patient's emotion and that you care about it. This can be done through sincere statements such as, "Ms. Foster, this is very hard" and handing a crying patient a tissue box.
3. Find effective ways to process emotions that are experienced with patients. These can include briefly acknowledging with the team the emotions felt by patients, yourself, and others. One medical student gave us the example of an attending physician who, after a patient died, simply said, "I'm really sad we lost that patient." It was a brief but clear acknowledgement of his emotions and allowed others to acknowledge theirs.

All too often the patient simply disappears and another appears in that bed without anyone even talking about the death. These responses—or lack thereof—send the message that there is no time and no need to even mention the death of that patient. Medical students and residents quickly pick up these messages and may think they are the only ones affected by the death and that they should not talk about it or express any sadness. Physicians may also be slow to acknowledge positive emotions when patients do well or they have a positive encounter with them. Acknowledging the emotions involved in

the clinical encounter can help physicians respond appropriately and maintain empathy throughout their careers.

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