Original Research Paper

Volume-7 | Issue-12 | December-2017 | ISSN - 2249-555X | IF : 4.894 | IC Value : 86.18

Medicine

BREAKING BAD NEWS IN CLINICAL SETTING: A SYSTEMATIC REVIEW

Dr Madhav Madhusudan Singh Asst Registrar, Military Hospital Meerut

Dr Rajiv Kumar Agarwal* Project Officer, Military Hospital Shimla *Corresponding Author

ABSTRACT Information that drastically alters the life world of the patient is termed as bad news. Conveying bad news is a skilled communication, and not at all easy. A growing body of evidence has demonstrated that most patients want to be informed about their illness, treatment and prognosis, whether this information is good or bad[1].

Most physicians experience difficulty when required to deliver bad news .The amount of truth to be disclosed is subjective[1]. A properly structured and well-orchestrated communication has a positive therapeutic effect. Giving patients accurate information about their health can help them make informed decisions about their treatment and take responsibility for their care[2], increase their understanding of their situation and help them to make appropriate plans for their future, prevent them from undertaking burdensome treatment and facilitate end-of-life care planning[3].

The communication of bad news can also be seen as a multidisciplinary activity which requires the active involvement of a wide range of healthcare professionals working as a team. Six-step SPIKES & ABCDE & BREAK protocol is widely used for breaking bad news. It is suggested that for more effective investigations, studies regarding interactional approaches in patients–medical team relationships be conducted on breaking bad news interventions.

KEYWORDS : Breaking bad news, protocol and guideline.

Introduction

Breaking bad news, defined as "any information which adversely and seriously affects an individual's view of his or her future,"[4] is a key moment in the relationship between oncologists and their patients. The moment is stressful for patients, especially if the clinician is inexperienced[5]. Over the past 20 years, medical communities have developed recommendations to improve the communication skills of health professionals,6 such as the 6-step SPIKES , ABCED , BROKE strategy designed for breaking bad news[6]. Educational programs provide an individual benefit to health professionals by improving their self-confidence in breaking bad news[7, 8]. This task nonetheless remains difficult for oncologists, and data about their experience regarding this daily situation are limited[9]. Large studies addressing the lived experience and focusing on burnout have reported a significant association between the time spent with patients and the risk of burnout[10,11], but these studies have not explored the domain of breaking bad news. Bad news can be categorized in the range of the need to undergo further laboratory or radiological tests to confirm a trivial diagnosis up to inform the patient of a life-threatening disease, such as cancer or informing the family or friends of death or disastrous morbidity of their patient [12-14].

So, there seems to be a wide consensus as to the importance of learning communication skills in the different stages of medical education [15]. However, education on delivering bad news effectively is dependent on the reliable and firm base of evidence[16].

Considerable amount of education and research information now exist regarding breaking bad news [17-19]. Many reports deal with the impact that bad news has on the deliverers and the recipients[20], and others contain useful guidelines and recommendations about what to do and say[21]. Therefore, in this study recommendations for facilitating breaking bad news were reviewed, and a suitable model was described for deliverers of bad news.

Bad news situations can include disease recurrence, spread of disease, or failure of treatment to affect disease progression, the presence of irreversible side effects, results of genetic tests, or raising the issue of palliative care and resuscitation. Studies have consistently shown that the way a doctor or other health or social care professional delivers bad news places an indelible mark on the doctor/professional-patient relationship[22].

Importance of Breaking Bad News

Breaking bad news to cancer patients is inherently aversive, described as "hitting the patient over the head" or "dropping a bomb". Breaking bad news can be particularly stressful when the clinician is inexperienced, the patient is young, or there are limited prospects for successful treatment[23].

Several Studies indicated that patients along with diagnosis also desired additional information. For example, a survey published in 1982 of 1,251 Americans [24] indicated that 96% wished to be told if they had a diagnosis of cancer, but also that 85% wished, in cases of a grave prognosis, to be given a realistic estimate of how long they had to live, although patient expectations have not always been met [25-28].

A study of 250 patients at an oncology centre in Scotland showed that 91% and 94% of patients, respectively, wanted to know the chances of cure for their cancer and the side effects of therapy [29].

In North America, principles of informed consent, patient autonomy, and case law have created clear ethical and legal obligations to provide patients with as much information as they desire about their illness and its treatment [30-31]. In India more or less the condition is similar as far as informed consent is concerned. A large number of expert and clinician tell they are not following this procedure of breaking bad news especially after death. As far as breaking news after diagnosis more or less all physician and surgeons are following but recording them on clinical note is not prevalent because of unawareness about recording is essential.

Physicians may not withhold medical information even if they suspect it will have a negative effect on the patient[32].

There is a physiological aspect of receiving the bad news. Any patient is not ready to receive any such news for which he or she is not prepared. It can change their lives soon after receiving the news.

The idea that receiving unfavourable medical information will invariably cause psychological harm is unsubstantiated[33-34]. Many patients desire accurate information to assist them in making important quality-of-life decisions. However, others who find it too threatening may employ forms of denial, shunning or minimizing the significance of the information, while still participating in treatment.

Barriers to Breaking Bad News

There are large number of barrier to breaking bad news to patient or / and Next of kin. Conveying bad news is more difficult when the clinician has a long-standing relationship with the patient, when the

patient is young, or when strong optimism had been expressed for a successful outcome[35].

Some of the important barriers are Strong emotions such as anxiety, a burden of responsibility for the news, and fear of negative evaluation. This stress creates a reluctance to deliver bad news, which he named the "MUM" effect. The MUM effect is particularly strong when the recipient of the bad news is already perceived as being distressed[36].

Strategy for Breaking Bad News ?

There should be a well plan for determining the patient's values, wishes for participation in decision-making, and a strategy for addressing their distress when the bad news is disclosed can increase physician confidence in the task of disclosing unfavourable medical information [37, 38]. It may also encourage patients to participate in difficult treatment decisions. Finally, physicians who are comfortable in breaking bad news may be subject to less stress and burnout [39].

Who should break bad news?

Ideally, bad news should be imparted by the lead consultant or senior non-consultant hospital doctor, who is known to the patient or in whom the patient has trust. In the exceptional circumstances of sudden death a senior member of the nursing staff may have to break bad news. Nurses may play a particular role in relation to breaking bad news in the inpatient clinical setting. They are often close at hand when the reality of a situation becomes apparent, and the patient and relatives feel the need to ask questions [40,41].

Patient's right wrt bad news:

Patients have a right to

- Accurate and true information
- Receive or not receive bad news
- Decide how much information they want or do not want
- Decide who should be present during the consultation, i.e. family members including children and/or significant others
- Decide who should be informed about their diagnosis and what information that person(s) should receive

Time for breaking bad news

As early as possible in the diagnostic process the multidisciplinary team should begin to prepare the patient for the possibility of bad news.

Approaches in breaking bad news

One of the most successful approaches in breaking bad news is through client-centered counselling, as proposed by Karl Rogers. He put forward three points in order to achieve a growth producing therapeutic relationship between the client (the patient) and the counsellor (the physician). According to Rogers, it is the client who knows what is hurting him most and he is the one who knows how to move forward. The fundamental insight of the client is exploited and the bad news is delivered in an orderly manner [42].

There are several strategy for braking bad news are described in various articles and in SOPs of various of hospitals. The important protocol are SPIKES, ABCDE & BROKE.

SPIKES: A Six-Step Strategy for Breaking Bad News:

The protocol (SPIKES) consists of six steps. The goal is to enable the clinician to fulfil the four most important objectives of the interview disclosing bad news: gathering information from the patient, transmitting the medical information, providing support to the patient, and eliciting the patient's collaboration in developing a strategy or treatment plan for the future[44].

Step 1: S—Setting up the interview
Step 2: P—Assessing the patient's perception
Step 3: I—Obtaining the patient's invitation
Step 4: K—Giving knowledge and information to the patient
Step 5: E—Addressing the patient's emotions with empathic responses
Step 6: S—Strategy

The six steps include[45] :

S – Setting

- Arrange for some privacy
- Involve significant others
- Sit down
- Make connection and establish rapport with the patient
- Manage time constraints and interruptions.

P – Perception of condition/seriousness

- Determine what the patient knows about the medical condition or what he suspects.
- Listen to the patient's level of comprehension
- Accept denial but do not confront at this stage.

I – Invitation from the patient to give information

- Ask patient if s/he wishes to know the details of the medical condition and/or treatment
- Accept patient's right not to know
- Offer to answer questions later if s/he wishes.

K – Knowledge: giving medical facts

- Use language intelligible to patient
- Consider educational level, socio-cultural background, current emotional state
- Give information in small chunks
- Check whether the patient understood what you said
- Respond to the patient's reactions as they occur
- Give any positive aspects first e.g.: Cancer has not spread to lymph nodes, highly responsive to therapy, treatment available locally etc.
- Give facts accurately about treatment options, prognosis, costs etc.

E - Explore emotions and sympathiz

- Prepare to give an empathetic response:

1. Identify emotion expressed by the patient (sadness, silence, shock etc.)
2. Identify cause/ source of emotion
3. Give the patient time express his or her feelings, and then respond in a way that demonstrates you have recognized connection between 1 and 2.

S – Strategy and summary

- Close the interview
- Ask whether they want to clarify something else
- Offer agenda for the next meeting eg: I will speak to you again when we have the opinion of cancer specialist

ABCDE model

It is a practical and comprehensive model, synthesized from multiple sources, was developed by Rabow and McPhee that uses the simple catchword ABCDE: advance preparation, building a therapeutic setting /relationship, communicate well, deal with patient and family responses, encourage and authenticate feelings [46].

Advance Preparation

- What the patient already know/understand already?
- Arrange for the presence of a support person and appropriate family
- Arrange a time and place to be undisturbed (Hand off beeper!)
- Prepare yourself emotionally
- Decide on which words and phrases to use—write a script

Build a therapeutic environment/ relationship

- Arrange a private, quiet place without interruptions
- Provide adequate seating for all
- Sit close enough to touch if appropriate
- Reassure about pain, suffering, abandonment

Communicate Well

- Be direct - "I am sorry that I have bad news for you."
- Do not use euphemisms, jargon, acronyms
- Use the words – "Cancer," "AIDS," "Death" as appropriate
- Allow for silence
- Use touch appropriately

Deal with patient and family reactions

- Assess patient reaction: physiologic responses, cognitive coping strategies, affective responses
- Listen actively, explore, have empathy

Encourage and validate emotions, Evaluate the News

- Address further needs: What are the patient's immediate and near-term plans, suicidality?
- Make appropriate referrals for more support
- Explore what the news means to the patient

- Express your own feelings

'BREAKS' Protocol for Breaking Bad News[47]

The BREAKS protocol as a systematic and easy communication strategy for breaking bad news. Development of competence in dealing with difficult situations has positive therapeutic outcome and is a professionally satisfying one. BREAKS' — B –Background, R-Rapport, E – Explore, A –Announce-; K-Kindling and S –Summarize.

Background : An effective therapeutic communication is dependent on the in-depth knowledge of the patient's problem. The accessibility of electronic media has given ample scope for obtaining enough data on any issue, though authenticity is questionable. It is highly desirable to prepare answers for all questions that can be anticipated from the patient. The physician must be aware of the patient/relative who comes after "googling" the problem.

Rapport : Building rapport is fundamental to continuous professional relationship. The physician should establish a good rapport with the patient. He needs to have an unconditional positive regard, but has to stay away from the temptation of developing a patronizing attitude. The ease with which the rapport is being built is the key to continue conversation.

Exploring : Whenever attempting to break the bad news, it is easier for the physician to start from what the patient knows about his/her illness. Most of the patients will be aware of the seriousness of the condition, and some may even know their diagnosis. The physician is then in a position of confirming bad news rather than breaking it. The history, the investigations, the difficulties met in the process etc need to be explored. What he/she thinks about the disease and even the diagnosis itself can be explored, and the potential conflicts between the patient's beliefs and possible diagnosis can be identified.

Announce : A warning shot is desirable, so that the news will not explode like a bomb. Euphemisms are welcome, but they should not create confusion. The patient has the right to know the diagnosis, at the same time he has the right to refrain from knowing it. Hence, announcement of diagnosis has to be made after getting consent.

Kindling : People listen to their diagnosis differently. They may break down in tears. Some may remain completely silent, some of them try to get up and pace round the room. Sometimes the response will be a denial of reality, as it protects the ego from a potential shatter.

Buckman suggested that the effect of bad news depends on the difference between the patient's expectations and the reality of the situation. Circumstances that can give rise to difficult conversations in clinical settings include [48-49]:

1. Informing a patient that his or her operation has been cancelled.
2. Informing a patient that his or her treatment will be delayed.
3. Confirming a diagnosis that will affect a patient's life expectancy and/or quality of life significantly.
4. Discussing a placement of choice for long-term care provision.

Varying responses to bad news from patient after hearing bad news :

People have varying responses when receiving bad news.

Some common ones are Denial, Shock, Anger, Guilt, Blame, Agitation, Helplessness, Sense of unreality, Misinterpreting information, and Regret/anxiety.

DO's in Breaking Bad News [50] :

- Allow for silence, tears and other patient reactions
- Allow time
- Be sensitive to the non-verbal language
- Document and liaise with the multidisciplinary team
- Ensure honest and simple language is used
- Ensure privacy and confidentiality and respect both
- Gauge the need for information on an individual basis
- Let the patient talk
- Listen to what the patient says

Don'ts in Breaking Bad News[50] ?

- Assume that you know what is concerning the patient
- Criticise or make judgements
- Distort the truth
- Feel obliged to keep talking all the time
- Give false reassurance
- Overload with information
- Withhold information

Guidelines on giving Bad News by telephone [50] :

The telephone is the least desirable mode of communication for breaking bad news. It should only be used in exceptional circumstances. A senior member of the medical/nursing staff should be the person who makes the phone call. Before making the call, it must be ensured there is sufficient time and privacy.

Communication – Skills[50]

Following communication skills required for breaking the bad news:

- Finding out the wishes of the patient about the involvement of family members
- Addressing situations where a patient does not wish family members to be involved
- Seeking or requesting consent from patients or families
- Addressing situations where a patient no longer has the capacity to discuss issues/give informed consent
- How to ensure that the wishes of the patient are fully respected
- Communicating with patients and families in difficult circumstances - including breaking 'bad news'
- Communicating with families of patients at end of life
- Consulting families to ascertain the patient's known wishes in respect of resuscitation and organ donation
- Face-to-face and telephone communication
- Use of appropriate language or terminology regarding sensitive issues at end of life
- Use of interpreters
- Identifying a family link/liaison person
- Cultural sensitive communication

Documentation of breaking bad news :

It is important that accurate records are maintained of the conversation and the information and details exchanged. These will assist in the future care of the patient and enhance communication within the multidisciplinary team including the patient's General Practitioner. This record should be documented in the patient's notes. The specific words used to describe the disease should be recorded, for example, tumour, growth or malignant disease.

The record should min include :

- Patients Name/Address:
- Hospital Number:
- Date and time of interview:
- Location: Ward /Outpatients
- Names of those present:
- Name:
- Position/Relationship:
- Clinical Diagnosis:
- Clinical Options for future management and immediate plan discussed:
- Detail of the words used when breaking the bad news:
- Sign of auth physician / social worker / MO :

CONCLUSION

Breaking bad news is part of the art of medicine. A bad news is always a bad news, however well it is said. But the manner in which it is conveyed can have a profound effect on both the recipient (the patient) and the giver (the physician). If done badly, it will hamper the well being of patient, impair the quality of life and future contact with the health care professional will be thwarted. It is a skill that has to be learnt by the physicians and other caregivers and effective methods of communication skills training are available[51].

Breaking bad news is a difficult undertaking for any health care professional. It can often change the lives of children, young people, their parents and families irrevocably. The quality of information provided to families depends on the education and training of the health care professionals who deliver the bad news.

References

1. Cox A., Jenkins V., Catt S., Langridge C. & Fallowfield L. (2006) Information needs and experiences: an audit of UK cancer patients. European Journal of Oncology Nursing 10, 263–272.
2. Tuckett A. (2004) Truth telling in clinical practice and the arguments for and against: a

review of the literature. Nursing Ethics 11, 500– 513.
3. WARNOCK C. , TOD A. , FOSTER J . & SORENY C. (2010) Breaking bad news in inpatient clinical settings: role of the nurse. Journal of Advanced Nursing doi: 10.1111/j.1365-2648.2010.05325.x
4. Buckman R (1992) Bad news: A guide for health care professionals (Johns Hopkins University Press, Baltimore). Google Scholar
5. Ptacek JT, Eberhardt TL (1996) Breaking bad news. A review of the literature. JAMA 276:496–502. CrossRefMedlineGoogle Scholar
6. Girgis A, Sanson-Fisher RW (1995) Breaking bad news: Consensus guidelines for medical practitioners. J Clin Oncol 13:2449–2456. Abstract/FREE Full Text
7. Hammond I, Franche RL, Black DM, et al. (1999) The radiologist and the patient: Breaking bad news. Can Assoc Radiol J J Assoc Can Radiol 50:233–234. Google Scholar
8. VandeKieft GK (2001) Breaking bad news. Am Fam Physician 64:1975–1978. MedlineGoogle Scholar
9. Baile WF, Buckman R, Lenzi R, et al. (2000) SPIKES-A six-step protocol for delivering bad news: Application to the patient with cancer. Oncologist 5:302–311. Abstract/FREE Full Text
10. Abel J, Dennison S, Senior-Smith G, et al. (2001) Breaking bad news–development of a hospital-based training workshop. Lancet Oncol 2:380–384. CrossRefMedlineGoogle Scholar
11. Fujimori M, Shirai Y, Asai M, et al. (2014) Effect of communication skills training program for oncologists based on patient preferences for communication when receiving bad news: A randomized controlled trial. J Clin Oncol, JCO.2013.51.2756. Google Scholar
12. Fallowfield L, Jenkins V (2004) Communicating sad, bad, and difficult news in medicine. Lancet 363:312–319. CrossRefMedlineGoogle Scholar
13. Eelen S, Bauwens S, Baillon C, et al. (2014) The prevalence of burnout among oncology professionals: Oncologists are at risk of developing burnout. Psychooncology 23:1415–1422. CrossRefMedline Google Scholar
14. Shanafelt TD, Gradishar WJ, Kosty M, et al. (2014) Burnout and career satisfaction among US oncologists. J Clin Oncol, JCO.2013.51.8480. Google Scholar
15. Meyer, G. S., Potter, A. & Gary, N. (1997). "A National Survey to Define a New Core Curriculum to Prepare Physicians for Managed Care Practice," Academic Medicine, 72 (8) 669-676.
16. Paul, C. L., Clinton-McHarg, T., Sanson-Fisher, R. W., Douglas, H. & Webb, G. (2009). "Are We there Yet? The State of the Evidence Base for Guidelines on Breaking Bad News to Cancer Patients," European Journal of Cancer, 45 (17) 2960-66
17. Abel, J., Dennison, S., Senior-Smith, G., Dolley, T., Lovett, J. & Cassidy, S. (2001). "Breaking Bad News-Development of a Hospital-Based Training Workshop," The Lancet Oncology, 2 (6) 380-384.
18. Back, A. L. Arnold, R. M., Baile, W. F., Fryer-Edwards, K. A., Alexander, S. C., Barley, G. E., Gooley, T. A. & Tulsky, J. A. (2007). "Efficacy of Communication Skills Training for Giving Bad News and Discussing Transitions to Palliative Care," Archives of Internal Medicine, 167 (5): 453-460.
19. Hawken, S. J. (2005). 'Strategies for Dealing with the Challenging Patient,' New Zealand Family Physician, 32 (4): 266-269.
20. Amiel, G. E., Ungar, L., Alperin, M., Baharier, Z., Cohen, R. & Reis, S. (2006). "Ability of Primary Care Physicians to Break Bad News: A Performance Based Assessment of an Educational Intervention," Patient Education and Counseling, 60:10–5.
21. Barnett, M. (2004). "A GP Guide to Breaking Bad News," The Practitioner, 248 (1659) 392-394, 399-400, 403
22. White paper 40th RFHHA Sunday Panel discussion on 09 Oct 2016 , 1000- 1400 hrs , Communicating Bad News to Next of Kin in Hospital, p-4
23. Walter F. Bailea, Robert Buckmanb, Renato Lenzia, Gary Globera, Estela A. Bealea and Andrzej P. Kudelkab , SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer , The Oncologist August 2000 vol. 5 no. 4 302-31.
24. Morris B, Abram C. Making Healthcare Decisions. The Ethical and Legal Implications of Informed Consent in the Practitioner-Patient Relationship. Washington: United States Superintendent of Documents, 1982:119.
25. Degner LF, Kristanjanson LJ, Bowman D et al. Information needs and decisional preferences in women with breast cancer. JAMA 1997;18:1485-1492.
26. Davidson JR, Brundage MD, Feldman-Stewart D. Lung cancer treatment decisions: patient's desires for participation and information. Psychooncology 1999;8:11-20.
27. Hoffman JC, Wegner NS, Davis RB et al. Patient preferences for communication with physicians about end-of-life decisions. SUPPORT investigators. Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment. Ann Int Med 1997;127:1-12. Medline
28. ↵ Lobb EA, Butow PN, Kenny DT et al. Communicating prognosis in early breast cancer: do women understand the language used? Med J Aust 1999;171:290-294.
29. Meredith C, Symonds P, Webster L et al. Information needs of cancer patients in West Scotland: cross sectional survey of patients' views. BMJ1996;313:724-726.
30. Goldberg RJ. Disclosure of information to adult cancer patients: issues and update. J Clin Oncol 1984;2:948-955. Abstract
31. Annas G. Informed consent, cancer, and truth in prognosis. N Engl J Med 1994;330:223-225.
32. Lind SE, DelVecchio-Good MJ, Seidel S et al. Telling the diagnosis of cancer. J Clin Oncol 1989;7:583-589.
33. Pfeiffer MP, Sidorov JE, Smith AC et al. and the EOL Study Group. The discussion of end-of-life medical care by primary care patients and physicians. A multicentered study using structured qualitative interviews. J Gen Intern Med 1994;9:82-88. CrossRefMedline
34. Tesser A, Rosen S, Tesser M. On the reluctance to communicate undesirable messages (the MUM effect). A field study. Psychol Rep 1971;29:651-654.
35. Approaching difficult communication tasks in oncology. Back AL, Arnold RM, Baile WF, Tulsky JA, Fryer-Edwards K CA Cancer J Clin. 2005 May-Jun; 55(3):164-77.
36. Tesser A, Conlee MC. Recipient emotionality as a determinant of the transmission of bad news. Proc Annu Conv Am Psych Assoc 1973;247-248.
37. Baile WF, Lenzi R, Kudelka AP et al. Improving physician-patient communication in cancer care: outcome of a workshop for oncologists. J Cancer Educ 1997;12:166-173. Medline
38. ↵ Baile WF, Kudelka AP, Beale EA et al. Communication skills training in oncology. Description and preliminary outcomes of workshops in breaking bad news and managing patient reactions to illness. Cancer 1999;86:887-897.
39. Ramirez AJ, Graham J, Richards MA et al. Burnout and psychiatric disorder among cancer clinicians. Br J Cancer 1995;71:1263-1269.
40. Norton S. & Telerico K. (2000) Facilitating end of life decision making: strategies for communicating and assessing. Journal of Gerontological Nursing 26, 6–13.
41. C. Warnock et al. Breaking bad news in inpatient clinical settings: role of the nurse. Journal of Advanced Nursing , Blackwell Publishing Ltd, https://www.researchgate.net/publication/44620268
42. Assessed on 11 oct 2016
43. Rogers CR. Foundations of the person centred approach. Educ. 1979;100:98–107
44. Baile WF1, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP.SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. Oncologist. 2000;5(4):302-11. https://www.ncbi.nlm.nih.gov/pubmed/10964998 , Assed on 11 Oct 2016.
45. Buckman, R. Breaking bad news: the S-P-I-K-E-S strategy. Community Oncology 2005; 2: 183-142. http://hiv.ubccpd.ca/files/2012/09/Summary-on-Breaking-Bad-News.pdf assessed on 11 Oct 2016.
46. Rabow MW, McPhee SJ. Beyond breaking bad news: how to help patients who suffer. WJM 1999;171: 260-263. http://www.journeyofhearts.org/kirstimd/AMSA/abcde.htm assessed on 11 Oct 2016
47. 'BREAKS' Protocol for Breaking Bad News , Vijayakumar Narayanan, Bibek Bista, Cheriyan Koshy , Indian J Palliat Care. 2010 May-Aug; 16(2): 61–65. doi: 10.4103/0973-1075.68401
48. Buckman, R. A. (2005). "Breaking Bad News: The S-P-I-K-E-S Strategy," Psychosocial Oncology, 2 (2):138-142.
49. Arezoo Ebn Ahmady, Shabnam Seyedzadeh Sabounchi, Hoori Mirmohammadsadeghi and Angelayalda Rezaei (2014), "A Suitable Model for Breaking Bad News: Review of Recommendations," JMED Research, Vol. 2014 (2014), Article ID 776618, DOI: 10.5171/2014.776618 http://ibimapublishing.com/articles/JMED/2014/776618/m776618-1.pdf assessed on 11 Oct 2016
50. End-of-Life Care Resource Folder Version 1, p-1-27, Irish foundation, http://hospicefoundation.ie/wp-content/uploads/2013/04/4.Communication.pdf assessed on 11 oct 2016
51. Efficacy of a Cancer Research UK communication skills training model for oncologists: a randomised controlled trial. Fallowfield L, Jenkins V, Farewell V, Saul J, Duffy A, Eves R Lancet. 2002 Feb 23; 359(9307):650-6.