

Breaking Bad News: A Primer for Radiologists in Breast Imaging

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The task of breaking bad news, whether news of need for biopsy or a new breast cancer diagnosis, is increasingly performed by breast imaging radiologists. Most radiologists have little exposure to didactic teaching or modeling for learning methods of breaking bad news. Understanding barriers for communicating bad news and general improvements in communication, such as avoiding jargon and active listening, are initial steps in learning this important task. Bad news should be communicated to a patient in a supportive environment and directly in simple, but not blunt, terms. The amount of news delivered at any one time must be judged by a patient's response. It may be preferable to deliver bad news in smaller portions to allow time for a patient to cope. The use of a "warning shot," particularly at the time of diagnostic imaging, can be helpful to alert patients to forthcoming bad news. Common patient responses to bad news include shock, disbelief, denial, fear, anger, and guilt. An empathetic response from a physician demonstrates support. In breast imaging, providing a patient with perspective about her risk for breast cancer or the characteristics of the cancer if early may instill hope without giving false reassurance. Establishing a plan, typically an appointment with a breast surgeon in the setting of breast cancer, allows a patient to have a sense of control over her disease. Offering additional support also demonstrates empathy. The task of delivering bad news is an important task that, if done well, improves patients' ability to cope with their disease.

Key Words: Bad news, patient communication, breast imaging, breast cancer, mammography

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The life of a sick person can be shortened not only by the acts, but also by the words or the manner of a physician. It is therefore, a sacred duty to guard himself carefully in this respect.

—American Medical Association, Code of Medical Ethics, 1847

Breaking bad news is not a common part of most radiologists' practice. Many radiologists leave this matter to the physicians requesting the studies. After all, breaking bad news is uncomfortable. We are not trained in this aspect of patient care and have little exposure to role models. Requesting physicians are likely to have ongoing relationships with their patients, making discussions of bad news a little more comfortable. So why should radiologists learn how to break bad news?

Radiologists are increasingly participating in patient management decisions and frequently perform diagnostic percutaneous biopsies and other procedures. In breast imaging, radiologists often discuss the need for biopsy with patients. Biopsy results may also be discussed with

patients by radiologists, including the diagnosis of a new breast cancer.

At our breast imaging practice, radiologists are typically the individuals who inform patients of the need for breast biopsies, as well as new breast cancer diagnoses found on biopsies. Giving patients perspective on the situation and appropriate levels of hope can help them move through the shock and denial phases to acceptance and proactive outlooks. The words chosen to communicate results may be remembered for many years by patients. In a survey of 100 women with breast cancer, adjustment to illness 6 months after diagnosis was correlated with their perceptions of how the bad news had been given [1]. Therefore, the choice of words and how they are said have a considerable impact on patients' perceptions of care.

The goal of this article is to increase radiologists' comfort level when giving bad news to patients and to improve their ability to provide support. Much of the information provided in this article is adapted from Robert Buckman's [2] excellent book *How to Break Bad News: A Guide for Health Care Professionals*, though we give the perspective of radiologists performing breast imaging. The suggestions provided can also be applied to other imaging situations. For example, all radiologists who per-

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form procedures will on occasion need to convey to patients or their family members that complications or other bad outcomes have occurred.

WHAT IS BAD NEWS?

Bad news is any information that will negatively alter patients' views of their future. The impact on a particular patient can be assessed only in the context of that patient's life. This primer is written primarily from the perspective of giving a patient the bad news of the need for breast biopsy because of abnormal breast imaging results and a new breast cancer diagnosis after a needle biopsy.

The truth about a patient's condition should be communicated in nearly all cases. Although telling the truth has been considered injurious in the past, 74% to 97% of patients want to know about their conditions, even if they are bad [2,3]. Breast cancer survivors often state that the most difficult period of time during their early cancer experience was waiting to learn the results of their biopsies. Without diagnoses, patients feel that they are in limbo. Once a diagnosis is known, a plan of action can be laid out.

Communication style and patient responses may vary by ethnicity [4]. For example, discussion of negative information may be perceived as doing harm for patients who are members of the Navajo, a Native American tribe in the southwestern United States [5]. As a radiology resident in Arizona, one of us (JAH) frequently experienced Navajo patients' requesting to only sign consent forms and waiving their right to discussions of informed consent for procedures. A full discussion would be perceived as predictive of a bad outcome. If in doubt, ask patients how much information they would like to know.

Likewise, because of Health Insurance Portability and Accountability Act regulations, bad news must be given directly to patients, unless they have expressly given written permission for news to be given to friends or family members. A husband, daughter, or other relative may ask to be given biopsy results. This is appropriate only if a patient requests that you communicate with a relative. It is important that a patient does not seem to be coerced into agreeing to this situation. If a patient does not speak English, use a translator to give the results to ensure that communication is accurate and that her questions and concerns have been addressed. Translation services are available by phone in numerous languages 24-hours a day (Cyraphone; CyraCom, Tucson, Arizona).

COMMUNICATION

Communication with patients can be improved by overcoming our own concerns about giving bad news, allowing patients time to talk, avoiding jargon, and becoming effective listeners.

Impediments to Communication

As physicians, we consider ourselves healers. We may avoid giving bad news because of a fear of causing pain. We may fear being blamed, particularly when the bad news is a complication or a failed procedure. Other impediments to physician communication include a lack of training, a fear of saying "I don't know," a fear of eliciting an emotional response, a fear of expressing personal emotions, and a fear of one's own mortality.

Patients Need to Be Heard. Patients are allowed to talk an average of 18 seconds before being interrupted by their physicians [2]. Dissatisfaction with physicians' communication skills far outweighs any dissatisfaction with technical competence [2]. Giving patients time to talk about their concerns takes only a minute or two. Physician empathy can considerably improve patient satisfaction.

Avoid Jargon. Bad news, whether it relates to the need for a biopsy, biopsy results showing cancer, or a complication, should be given in plain terms. This need not be blunt. Medical jargon is unintelligible to patients and may lead to misunderstanding. Many patients misunderstand a significant portion of what physicians communicate. For example, of 143 women diagnosed with breast cancer, 73% did not understand the term "median survival" [6]. Try to gauge the level of understanding for each individual patient. Try to use their questions to guide you to their levels of understanding.

Improving Communication

A patient should be physically comfortable, in a quiet room without distractions or interruptions. Be at eye level with the patient. Physical contact such as a handshake or a comforting hand can establish your level of concern for the patient's well-being.

After breaking bad news, effective listening is important. A patient should be encouraged to speak. Active listening skills, such as repetition, reiteration, and reflection, can reassure the patient. Do not interrupt the patient unless absolutely necessary. Short pauses can occur when emotions are intense. Responding to the patient appropriately is important. This can manifest as asking further questions, making a statement, or silence if you are in the physical presence of the patient.

Radiologists may worry that talking with patients is too time consuming. However, actual face-to-face time is much shorter than the amount of time perceived by patients. A few minutes spent talking with a patient is very much appreciated.

Telephone Vs in Person. Giving bad news occurs in breast imaging primarily in two situations: abnormal imaging results that require biopsy and breast cancer diagnoses

found on image-guided biopsy. Communication of the bad news that a biopsy is recommended because of abnormal imaging findings can be done in person at the time of diagnostic mammography or ultrasound. It is likely that a definitive recommendation could be made at the time of diagnostic imaging while the patient is still present. The radiologist can begin establishing a relationship with the patient at this encounter. The patient can also be introduced to a contact person in the breast center, such as a nurse or technologist. At our institution, after abnormal results are briefly discussed with patients, they are introduced to our nurse navigator, who discusses the details of the procedure, reviews medications, and gives them appointments. Patients leave with the nurse's business card and with telephone numbers should they need additional information. This process helps establish relationships with the radiologists and the nurse, who are readily accessible to the patients throughout the experience.

The University of Virginia Breast Program serves a large regional catchment area. Although giving bad news of a breast cancer diagnosis in person may be optimal, returning to the facility creates a burden for many patients. Therefore, breast needle biopsy results are nearly always communicated by telephone. If biopsy results are benign and concordant, the nurse navigator (who established rapport with the patient when the biopsy was scheduled) calls the patient with the good news. If the biopsy shows cancer, the radiologist who performed the biopsy calls the patient with the results. The nurse navigator calls the patient later the same day or on the following day to assess the patient's response to the bad news and to answer any additional questions.

Patients know ahead of time that we will not leave phone messages with biopsy results, whether they are benign or show cancer, though we will leave messages telling the patients that we have the results and when to call back. Patients, of course, have the option to return to the Breast Care Center to receive the results in person if they prefer, though very few choose to do so.

When bad news is given over the telephone, make sure the patient is in an appropriate environment, preferably in a private location other than work. Ensure that you are not talking with the patient on a cellular phone while the patient is driving. Because you will not be able to judge visual cues regarding the patient's response, ask the patient to verbalize responses to the information.

Communicating Bad News

It may be tempting to leave the communication of bad news to a primary care or referring physician. However, as a breast imager, you have the best vantage point for giving a patient perspective about bad news. If you have reviewed the mammogram and other imaging, you will have some idea as to the size of the breast cancer, whether

the patient may be a candidate for breast conservation, and so on.

Radiologists performing ultrasound or magnetic resonance imaging for breast diagnosis or image-guided biopsy may also find themselves in the role of giving bad news of breast cancer diagnoses to patients. In the case of breast magnetic resonance imaging, communication with a patient by an interpreting radiologist is more likely to occur by telephone than in person, because the patient would likely have left the facility before study interpretation.

Good communication with patients is also important for radiologists who perform image-guided procedures of all types, primarily if complications occur or if there is a suboptimal outcome. Communication of the bad news of a procedure complication or poor outcome with the patient or family is best done by the radiologist who performed or supervised the procedure. The patient or family may experience disillusionment about the level of care in these circumstances. If radiologists choose to not personally discuss the situation with the patient or family, they may be perceived as disengaged, leading to further disappointment. This may increase susceptibility to a lawsuit.

Models of communication of bad news are numerous. Among the choices of patient-centered, emotion-centered, and disease-centered models, women prefer the patient-centered model [7]. This model is characterized by dosing and timing of the communication of information according to patients' needs and encouraging patients to discuss their feelings and concerns [7]. Patients report the most satisfaction and least increase in negative emotions with patient-centered communication [7]. Most approaches share in common building a therapeutic environment, communicating results, responding appropriately to the emotions generated, providing a strategy for dealing with the bad news, and encouraging hope [8-11]. Table 1 provides sample phrases based on the patient centered model of discussing medicine.

The objectives for communicating bad news in the setting of a new breast cancer are to provide a diagnosis, discuss prognosis and a treatment plan, and offer support. In the case of diagnostic imaging that results in the need for biopsy, the objectives are discussion of the findings, likelihood of the findings representing cancer, and the plan of action. Good communication of the results does make a difference. In a survey of 100 breast cancer survivors, adjustment to illness was correlated with physicians' behavior during the diagnostic interviews, as well as comorbid psychiatric conditions and life stressors [12]. Women's perceptions of communication skills during the diagnostic interviews, positive or negative, are associated with later psychological adjustment [13].

Throughout the following sections, text in italics represents sample statements that may be made by a radiologist.

Table 1. Steps in communicating bad news

| Step | Sample Phrases |
|--|---|
| Prepare <ul style="list-style-type: none"> ● Private location ● Same eye level as patient ● No interruptions ● Have follow-up appointment information available | “Would you like a family member or friend to be present?” |
| Disclose the news <ul style="list-style-type: none"> ● Warning shot ● Give information in simple terms ● Providing perspective for the information ● Gauge amount of news given by patient’s ability to cope | “I’m concerned about what I see on your mammogram.” “The mammogram shows some new calcifications. These look like sand on the mammogram and can be the earliest finding of breast cancer.” “I’m afraid that I have some bad news. The biopsy did show breast cancer. (Pause) As you recall (from our conversation during the diagnostic evaluation), the area is small in size; about the size of a pea. Most women with cancers of this size do quite well.” |
| Evaluate the patient’s response <ul style="list-style-type: none"> ● Allow silence ● Allow expression of concerns ● Provide empathy | “I know that this is hard news coming out of the blue like this.” “What are your thoughts and concerns?” “What worries you most about this?” |
| Discuss the next step <ul style="list-style-type: none"> ● Appointment for breast surgery | “The next step is usually surgery. I have an appointment for you to see Dr. Brenin, one of our breast surgeons, next Wednesday, at 11 am. At that appointment, you’ll talk about the types of surgery available and other treatment that may be necessary.” |
| Offer support <ul style="list-style-type: none"> ● Resources for information and support ● Contact information for additional support (nurse or physician) | “We will mail a packet of information to you. Please feel free to call me or our nurse, Betty, if there is anything that you want to discuss between now and the surgery appointment.” |

The Warning Shot. Giving bad news in plain terms does not mean that it must be dropped like a bomb on a patient. The bad news must be communicated, but a level of judgment is necessary in deciding when, how, and how much bad news to give. In some circumstances, it may be possible and preferable to give the bad news in stages.

If a patient has an obvious cancer on her diagnostic mammogram, the point at which she receives her cancer diagnosis can depend on her ability to cope with the news (Figure 1). A “warning shot” can be helpful in preparing the patient for the eventual bad news. An initial statement, such as “*I’m pretty concerned about this area,*” allows an opportunity to gauge the patient’s response. If the patient seems to be increasing in anxiety level or approaching the point of breaking down, enough has been said for that point in time. On the other hand, if a patient is dealing with the stress adequately and is inquiring about how likely the biopsy is to show cancer, additional information can be given. A subsequent statement, such as “*I think that your biopsy might show breast cancer,*” can be made. This allows the patient to begin processing her

emotional response to that potential outcome. If the biopsy does show cancer, the patient will be further along in the grieving process when the bad news is actually communicated.

If a breast lesion is suspicious but not malignant in appearance, the warning shot should be dampened. A statement, if applicable, that the odds of cancer are small (10% to 30% risk) and that, if present, cancer would likely be at an early stage may be more appropriate. Likewise, it is important to discuss potential complications, even if uncommon, before a procedure so that patients (and possibly family members) know that the risk for a complication is small but real.

Using the “C” Word. After receiving bad news, shock can cause disruption in a patient’s ability to process further information. Specifically, using the word *cancer* can result in cognitive disruption for the patient. Much of what is said after the word *cancer* is not heard by the patient. However, it is not until the bad news is received that the grieving and healing

"Hi Mrs. Smith, I'm Dr. Harvey."
 "Nice to meet you."
 "Would you like to have a friend or family member present?"
 "No, that's okay. I'm here by myself."
 "Okay. I would like to talk with you about your mammogram."
 "Okay."
 "In your left breast, there is a small area that looks different compared to your older mammograms. This area concerns me." (The warning shot)
 Okay.
 "I would recommend a needle biopsy of that area to find out what is going on there."
 (The bad news)
 "That sounds okay."
 Option 1: The patient is tearful. You move closer to the patient and offer her tissues.
 "This is difficult news to hear. How are you feeling?"
 After some discussion, you have her meet with your nurse who gives her information about the biopsy, an appointment (The Plan), and a phone number to call back if she has questions or concerns.
 Option 2: The patient appears to be coping with the bad news so far and asks:
 "Do you think that it's cancer?"
 "I think that the biopsy may show cancer (stronger warning shot). The area that I see is pretty small though; about the size of a pea. If the biopsy does show cancer, it is likely that it would be at an early stage (perspective) though we won't know for sure until the biopsy is done." (The Plan)
 The patient meets with the nurse, receives information about the procedure and a phone number to call for questions or concerns. She leaves with an appointment for the biopsy.
 (The Plan)

Fig 1. Breaking the news of a need for a biopsy with a highly suspicious lesion on mammography.

processes can begin. Bad news needs to be processed and that can take time.

One of us (RBA) had an experience in which a patient was referred by a family physician to the Gastrointestinal Clinic for consultation for treatment of a newly diagnosed colon cancer. The patient and his family drove several hours to attend the appointment. The attending physician entered the room and asked the patient about what kind of treatment options had been discussed with him for his colon cancer. The patient's response was, "I have colon cancer?" Apparently, the family physician and general surgeon who had performed the initial biopsy had failed to discuss the diagnosis with the patient. The next 30 minutes were spent supporting the patient regarding his new diagnosis. He returned 2 weeks later, after the shock of the cancer diagnosis had dissipated, and he was then ready to discuss treatment options.

The word *cancer* should be used specifically when appropriate. At what point in time the word *cancer* should be used is debatable and often depends on a physician's judgment. If it is likely that a patient does have cancer, on the basis of clinical or imaging findings, a warning shot that a biopsy is needed and may show cancer can help the patient begin the grieving process. On the other hand, the word *cancer* should probably be avoided if the biopsy is more likely to be benign. Some assessment of the patient's emotional state must be made. If the patient seems on the verge of emotional breakdown at the mention of the need for biopsy, it is likely better to let her process that bad news before adding that cancer is the likely diagnosis.

Patient Responses

Kubler-Ross [14] revolutionized our thinking about death and dying by defining the 5 stages of grief. However, the reaction to bad news is often more complex. Patients respond to bad news in many ways. The responses that they use are often the coping mechanisms that they are accustomed to using in any stressful situation. Robert Buckman [2] termed this "the portrait in miniature." An advantage of thinking of the emotional response in this way is that a patient's friends and family members are often familiar with the patient's coping mechanisms and can serve as allies in helping the patient through a difficult time. In a study of patients with cancer, the most frequent responses were shock (54%), fright (46%), acceptance (40%), sadness (24%), and "not worried" (15%) [15]. It is not a physician's job to decide if a patient's reaction is normal or abnormal, but whether the behavior will help the patient cope.

It is also helpful to realize that reactions can be mixed, even during the same visit or phone call. Consider a mother who has become separated from her child at a store or park and now sees the child. Her reactions may simultaneously include relief, happiness at locating the child, guilt, and possibly anger or irritation at the child.

Shock or Disbelief. The initial response to bad news is frequently shock or disbelief. Shock can be recognized when there is a temporary failure of normal cognitive functioning. Patients may not be able to speak or respond to verbal stimuli. They may go through motions that seem superficially normal, but they are clearly distracted. They exhibit mental dulling. Disbelief, like shock, is a sign that patients are having difficulty processing information, though they are trying to do so. Patients may make statements such as "I can't believe it." Disbelief should be distinguished from denial, which manifests as a patient's refusal to accept information. Both shock and disbelief are common when bad news is unexpected. This can occur when a breast cancer is detected on a screening mammogram in an otherwise healthy patient (Figure 2), or when an uncommon complication occurs after a procedure.

Prolonged silence is often a manifestation of shock. Many patients report not hearing anything after they hear the word *cancer*. It is often useful to let the silence hang for a minute or so while the patient processes the information. Remember, the patient is unlikely to recall what you say in the next 60 seconds after using the word *cancer* anyway.

An earlier warning shot can be helpful in reducing a shock or disbelief reaction. If a patient was alerted to the possibility of a breast cancer diagnosis at the time of diagnostic mammography, then she is more likely to have already moved beyond the shock and disbelief phase at

"Hello?"
 "Hello. Is this Mrs. Jane Smith?"
 "Yes. It is."
 "This is Dr. Harvey from the UVa Breast Care Center. How are you doing?"
 "Okay. Just waiting to hear what my biopsy showed."
 "Are you at a place where we can talk?"
 "Yes. I'm at home."
 "Well I have your biopsy results and I'm afraid that it's bad news." (The warning shot)
 "Oh? What did the biopsy show?"
 "The biopsy showed cancer." (The News)
 Silence. Let the patient process (The News)
 "I know that this must come as a shock to have news like this out of the blue."
 (Acknowledge the shock)
 "Mmm-hmm." Further silence, then, "So, what does this mean?"
 "Well, the biopsy showed ductal carcinoma in-situ, which is the earliest kind of breast cancer. It's also called DCIS. This just means that it is a cancer that comes from the milk ducts, which are the tubes that carry the milk to the nipple. When the cancer is only inside the milk duct, it is called in-situ. This kind of cancer is very treatable." (Perspective and Prognosis)
 "So what happens now? Am I going to have to have a mastectomy or something?"
 "Well, the next step is surgery. I've made an appointment for you to see one of our breast surgeons, Dr. Brenin. He can see you on Wednesday at 2 pm in the Breast Care Center. At that appointment, he will meet you, do a breast exam, and review your mammograms and biopsy results. The options for treating breast cancer are usually lumpectomy, where only the part of the breast with cancer is removed, or mastectomy, where the breast is removed. It sounds like you're worried that you might need a mastectomy?"
 "Yeah, I don't want that."
 "I would talk with Dr. Brenin about it. He can give you very good advice about what kind of surgery would be best." (Did not offer false reassurance)
 "Okay."
 "But ultimately, you will decide what kind of surgery you would like to have. Do you have other concerns?"
 "Am I going to need chemotherapy?"
 "What are your concerns about chemotherapy?"
 "I hear that it makes you really sick and I don't want to lose my hair."
 "Women with this kind of breast cancer often do not need chemotherapy, but that may depend upon what is found at surgery. Do talk with Dr. Brenin about your concerns though. Anything else that you want to talk about?"
 "No, I don't think so."
 "Okay then. I would suggest that you write down your questions and bring them with you to the appointment with Dr. Brenin. It's also a good idea to bring a family member or friend with you. And remember that you can call us back too if you have other questions."
 (Offer Support)
 "I'll do that. Thanks for calling."

Fig 2. An example case of giving a patient the news of biopsy results showing breast cancer. A "warning shot" was given at the time of diagnostic mammography, when the need for a breast needle biopsy was discussed.

the time the practitioner is disclosing results. It is not uncommon when we tell a woman that her biopsy showed breast cancer that she responds by saying, "Well, you thought that it might show cancer." The patient is often ready to discuss the prognosis and treatment plan by that point.

A frequent temptation for caregivers is to back off or down play bad news. We want to make patients feel better. We may make a statement such as "Cancers like this are always cured." If the patient later is discovered to have more extensive disease, trust in the radiologist is jeopardized.

Denial. Patients are exhibiting denial when they refuse to believe bad news and express the belief that the bad news is not real or is an error. Denial can be temporary or

long-lasting. It may manifest with displacement behavior. For example, patients may occupy themselves with activities such as reading magazine articles, without expressing emotional responses until a later time. Temporary denial can be a reasonable coping mechanism whereby processing of bad news is delayed until a patient is ready to take on the emotional response. A response that is empathetic ("I know this information must be hard to accept, because it is so unexpected") and moving to discussion of a treatment plan avoids a confrontation with the patient.

The overexpression of hope is a form of denial. A patient may state that because her cancer was found on a mammogram, she is sure that she will be cured. This response can also be disruptive to obtaining appropriate treatment.

Information Gathering. This is a form of displacement of grief whereby the emotional response is focused on gathering information about the disease process. This can be a very empowering coping mechanism, allowing patients to gain a sense of control over their disease. The grief must eventually be admitted, though, and processed emotionally for this to be a positive coping mechanism. Information gathering can manifest as obtaining a second opinion. This can likewise be very empowering, though it can be taken to an extreme by patients who "doctor shop," seeking positive information that does not exist.

Fear and Anxiety. These are common, normal responses to hearing bad news. Identifying and acknowledging the cause of the fear or anxiety may be helpful. For example, a patient may respond to the news of breast cancer by stating that her mother died of breast cancer. An empathetic or open-ended response, such as "That must have been difficult for you or Have you been thinking about what might happen to you?" may allow the patient to verbalize her fears. A response such as "What is it that worries you most?" is often useful to communicate permission to discuss the patient's concerns. Educating the patient about the prognosis and treatment may reduce fear and anxiety.

One of us (JAH) had an experience in which a patient responded to the news of the need for a biopsy by stating that she would not have anything done. When asked about her concerns, she repeated that she would not have a biopsy. Fortunately, her husband was also present. He explained that their son had recently died after a long battle with leukemia requiring difficult and unsuccessful chemotherapy treatments. The patient was very worried that she would also undergo very difficult treatment and ultimately die despite therapy. We talked about the small size of the mass for which biopsy was recommended and how it was likely to be an early stage if the biopsy did

show cancer. We also discussed that she could choose whatever treatment was comfortable for her; for example, she could choose surgery without chemotherapy if she wanted. She subsequently underwent core needle biopsy that showed invasive ductal carcinoma. She underwent lumpectomy with partial breast irradiation and treatment with tamoxifen.

As physicians, we must be careful to not offer false reassurance. In our role as caregivers, we want to relieve patients' anxiety. The temptation to relieve that stress through overreassurance increases when a patient has a high level of distress by making statements such as "*Small breast cancers like this are always cured.*" Physicians need to recognize this trait in themselves and work to avoid it.

Anger. Patients may demonstrate angry or aggressive responses to bad news. This is usually a manifestation of fear. It is frequently displaced on the nearest person, who may be a physician, receptionist, or technologist. An aggressive response on the part of a physician will end the therapeutic relationship. Instead, find the root cause of the anger and address it. For example, a woman presented to our Breast Care Center for a diagnostic mammogram during a time when we have a standing weekly meeting. She angrily insisted that she had an appointment. Although some staff members mumbled that she should go elsewhere for care, one technologist immediately responded by doing the patient's mammogram, realizing that she was just very anxious about having a breast problem. Fortunately, the subsequent imaging results were negative. The patient was much relieved and apologized for her initial behavior. Undergoing breast imaging, even screening mammography, can elicit a considerable amount of anxiety for women. It is not uncommon to observe initial angry behavior by patients, followed by sheepish gratitude after the stressor is relieved, particularly after negative examination results.

Anger may be abstract or directed against the disease, loss of control, or loss of potential. Anger can also be directed against self, friends and family, medical professionals, or God. Acknowledgment of the emotion with a statement such as "*You sound angry that you weren't referred for a mammogram earlier*" may evoke further expression of anger but will often allow the discussion to move on after patients have vented their feelings. Validating a patient's response ("*You're right, Dr Jones should have sent you for a mammogram earlier*") will not dispel the anger and may serve as fuel for the pursuit of a medicolegal process. Likewise, engaging the patient's anger by becoming hostile or defensive will only escalate the situation and alienate the physician from the patient.

Blame. Blame is focused anger displaced onto another individual or circumstance. This has particular implications for lawsuits. Discussing a patient's feelings may

reduce the displaced anger. It is important not to validate blame that is verbalized by the patient toward others, especially health care providers. Often, more is present to the circumstances than may be communicated by the patient. By providing an empathic response, you are neither agreeing nor disagreeing about the appropriateness of the blame, only letting the patient know that it is okay to talk about the anger. Discussing the feelings of anger may help the patient move through the process to a more constructive response.

Guilt is Self-blame. There is often a component of regret or sorrow. Guilt may result in behavior modification that may improve a patient's outcome (eg, doing breast self-examinations regularly) but is otherwise a poor coping mechanism. It may be the eventual outcome of denial. An open-ended or empathetic response allows a patient to talk about her sense of guilt.

Crying. Crying is a common and normal response to stress. It can be a physical manifestation of many different emotions. When crying occurs, do not pull away. Offer tissues. Ask the patient what she is concerned about that is making her cry. The response may be surprising. For example, a patient may fear hair loss, because she associates this with her mother's death from breast cancer. Let the patient calm down before you leave the room. Ask if she would like to talk with a family member or friend. This allows transfer of support of the patient without abandoning her.

Why Me? Although it is true that a certain percentage of the population will develop a certain disease, to state this factual response to a patient's question ignores the patient's emotional response and seems indifferent. Instead, an open-ended or empathetic response such as "*This must be difficult news*" communicates support.

Humor. Humor is often a very healthy way to deal with stressful situations. However, some patients laugh or smile when they are nervous or even angry. Sometimes jokes are used to present a sense of bravery, though it is false. If laughter, jokes, or smiles seem to not be quite right, ask the patient how she is feeling about what you are discussing. Her verbal response may clarify the situation.

Physician Response

It would be ideal if physicians uniformly offered warm, empathic responses to all of their patients. In reality, we all have moments when our limits are reached. Sometimes our own stress levels are high, and we are less able to manage patients' stress. We may withdraw from patients, rescind the bad news to some extent, feel guilty about our own lack of ability to find every cancer at a curable stage, or even become angry.

The appearance of anger on the part of a physician in a patient interaction can be devastating. If you are feeling angry, having a colleague take over care of the patient temporarily may allow the situation to diffuse. If you are feeling angry during the interaction, it is okay to verbalize (but not display) your feelings: *“I’m sorry that I’m becoming impatient.”* If you do display your anger, wait until you are no longer angry. Then speak to the patient about why you were angry. This will define unresolved issues. It may be tempting to walk away from the situation, but following up with the patient is important to resolve the issues.

When issues cannot be resolved with a patient, refer the patient to your hospital or institution’s patient care representative (*“I sense that you are still not satisfied that I’ve met your needs. I would suggest that you call one of our patient care representatives at 555-1212 to discuss your concerns”*). The people who staff these offices are typically expert at analyzing the emotional components of patients’ responses and facilitating resolution. On rare occasion, care of the patient may need to be transferred to another physician or clinic.

Discuss Prognoses and Treatment Plans

Hope Is a Strong Motivator. When bad news is delivered, providing the patient with some perspective of the diagnosis is key to driving hope. It is important to communicate what the bad news means and specifically what it will mean for that patient. Radiologists are in the best position to provide this information, because we are familiar with patients’ breast imaging studies. For example, if a cancer has good prognostic features, such as being in situ, low grade, or small size, these should be discussed with the patient (Figure 3). Breast cancers that are detected by screening mammography and perceived as likely curable are associated with lower psychological morbidity than breast cancers that present as palpable lumps [16]. False reassurance, however, should not be given. A blanket statement that a patient will be cured, for example, is misleading and could result in medicolegal action because of the miscommunication. Use facts when possible.

A patient will want to know what the next step will be after bad news is given. The radiologist need not be specific about a treatment plan. An appointment with a surgeon can be helpful so that the patient has a concrete plan of action at the end of the conversation. When patients undergo breast needle biopsies that show cancer, we give them appointments to see breast surgeons as the next step. It is important that the patient understands that the appointment is for an office visit rather than the actual surgical procedure. If referring physicians prefer to make surgical appointments directly, let the patient know that the next step is to see a

“Hello?”
 “Hello. Is this Mrs. Jane Smith?”
 “Yes. It is.”
 “This is Dr. Harvey from the UVa Breast Care Center. How are you doing?”
 “Well, okay. I still have a little bruising from my biopsy.”
 “Are you at a place where we can talk?”
 “Let me just go into the other room. Okay.”
 “Alright... I have your breast biopsy results... The biopsy did show cancer.” (The News)
 Silence. Then, “Well, you thought that it might.”
 Silence (let the patient take in The News for a few moments)
 “The biopsy showed invasive ductal carcinoma, which is the most common kind of breast cancer. Now remember that when we talked (at the time of the diagnostic exam) I told you that the mass that we saw was about the size of a pea. Most women with cancers of this size do very well. In fact, 90% of women with cancers that are less than one centimeter in size are alive and doing fine five years after their diagnosis.” (Prognosis)
 “What should I do now?”
 “The next step is surgery. I have an appointment for you to see one of our breast surgeons next Monday at 10:30 am, at the Breast Care Center. At that appointment, the surgeon will review your mammogram, do a breast exam, and ask you about your medical history. You and he/she will discuss what kind of surgery will be done and when. The surgery is usually a week or two after the appointment. (The Next Step) Do you have any questions?”
 “Will I need to have a mastectomy? What about chemotherapy, because I don’t want that.”
 “Most, but not all, women with small cancers like this can be treated with a lumpectomy where just part of the breast is removed. I’m not sure if you will need chemotherapy or not. Dr. Jones will be able to give you more information on Tuesday. If you have concerns about having chemotherapy though, I would definitely talk with him about your concerns (did not give false reassurance that she would not need chemotherapy). You’ll figure out a plan that will work for you. I would also suggest that you write down these questions and bring a friend or family member with you to the appointment. Anything else that you would like to talk about?”
 “No. This is a lot to take in.”
 “Yes, it is. I’m sorry to give you this news. Please remember that most women with cancers of this size do well. Please call me back if you have any questions. You have the phone number on your biopsy information sheet, but I can give it to you again.” (Offer Support)

Fig 3. An example case of giving a patient the news of biopsy results showing ductal carcinoma in situ in which the lesion was a nonspecific cluster of microcalcifications. A “warning shot” was not given during the discussion of the need for a breast biopsy.

surgeon and that the patient’s referring physician’s office will be contacting her with the appointment information. A concrete plan will help focus the patient on treating the cancer and helps the patient feel some sense of control.

A radiologist can also give basic information to a patient about the next step in the treatment plan if the radiologist feels comfortable doing so. This may be information regarding the possibility of breast conservation, the need for radiation therapy, or whether chemotherapy may be prescribed. Alternatively, or when the questions become too specific, one can say, *“I am a specialist in finding breast cancers. I don’t know the answers to those questions, but the doctor you will be seeing on Monday is a specialist in treating cancers and can answer your questions.”* Encourage patients to write down their questions and bring them to their appointments. Likewise, it is very helpful to have a friend or family member accompany the patient to the appointment to help with active listening, by taking notes and

ensuring that questions are answered. The American Cancer Society's Web site (<http://www.cancer.org>) is also an excellent resource for patients with newly diagnosed cancer.

Offer Support

Close the conversation by asking if the patient has any further questions or concerns. If there are family members or friends with the patient, also ask if they have any questions or concerns after you have answered the patient's questions. Tell the patient that she can call you or your nurse if any questions or concerns arise. It is extremely uncommon for a patient to call back with more questions, but patients are very grateful for the offer of continued support. It can also be helpful for the referring physician or breast center nurse to call the patient later on to check on how she is coping and to see if she has any additional questions.

CONCLUSIONS

Giving a patient bad news can be uncomfortable. A patient's response to bad news is often typical of the patient's usual coping mechanisms. The initial response is often shock or disbelief. Responses may be helpful, such as information gathering, or unhelpful, such as anger or guilt. Open-ended questions or empathetic responses are usually the most appropriate way to respond to patients who have received bad news. Hostile responses jeopardize the physician-patient relationship.

Bad news can be life changing for a patient. Most patients remember the precise moments that they were told they had cancer. The high anxiety state amplifies their responses. Although it is unlikely that a physician will recall the conversation later, a patient is likely to recall every word and how it was said. If the patient perceives the interaction as cool or distant, it may be remembered as nearly cruel. If the interaction is perceived as kind and supportive, it will be remembered as being exceptionally kind. Breaking bad news well is an important role of physicians, who can help ease the pain

of hearing the news, helping patients move closer to treatment and hopefully cure.

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