Chapter 5

Breaking Bad News in the Provider-Recipient Context: Understanding the Hesitation to Share Bad News from the Sender's Perspective

Jayson L. Dibble

Introduction

Arguably, information represents the most critical commodity in healthcare settings. Providers and recipients both require timely and accurate information to make the best decisions regarding the recipient's care. Unfortunately, health outcomes are not always positive. Healthcare providers often find themselves in the position of having to share negative information with their recipients and their recipients' families. Sharing negative information is commonly referred to as breaking bad news. And because bad news typically contains information directly relevant to the recipient, it is important that providers are able to break bad news optimally.

Breaking bad news is not straightforward. It is an inherently complicated process involving several interrelated communication events, each influenced by myriad variables. For example, at a minimum, providers must initially recognize the information (i.e., the "news") as unfavorable, make ongoing assessments of how negative the bad news is (i.e., its severity), consider the outcome(s) signaled by the bad news, and determine the way(s) in which to relay this information to the recipient. Moreover, those who deliver bad news accomplish these tasks with considerable variability (Dibble, 2008; Dibble & Levine, 2010).

Of course, all the events of the previous paragraph occur amid a tangle of actual emotional reactions and anticipated future emotional reactions. Thus, it is not surprising that providers who claim confidence at breaking bad news are rare (e.g., Rider, Volkan, & Hafler, 2008). Complicating matters further, providers face a great deal of resistance to share bad news in the form of physical and cognitive reluctance. At times this reluctance hampers the communication goal(s) of the provider-recipient encounter. Namely, the recipient does not get the information he or she needs. For example, physicians who suspected dementia diagnoses in their patients have delayed sharing these suspicions with the patient or the patient's

family for up to two years (Paterson & Pond, 2009). Other physicians, seeking to soften the impact of the bad news, have (in)appropriately resorted to the use of implicit language (Del Vento, Bavelas, Healing, MacLean, & Kirk, 2009). In these situations, it is not difficult to imagine certain recipients taking offense at their physician's "failure" to level with them. Other evidence points to sizable stress-related and emotion-related personal costs incurred by providers (Buckman, 1984; Harrison & Walling, 2010; Ptacek, Ptacek, & Ellison, 2001). To further exacerbate the issue, many providers report receiving inadequate training in breaking bad news, if they received any training at all. A recent national survey of psychologists found that only 2.7 percent of the sample (N = 329) claimed familiarity with existing guidelines (Merker, Hanson, & Poston, 2010). In sum, the situation of breaking bad news carefully is a critical one, but it is fraught with costs, drawbacks, hesitancies, inadequacies, and opportunities for miscommunication.

This chapter addresses the situation of breaking bad news interpersonally from healthcare providers to their care recipients. Specifically, we focus on the bad news delivery process from the perspective of the one giving the bad news. As we show, this perspective is not well understood and is only recently being taken up by researchers. Guided by these goals, this chapter is organized as follows. First, we define and explicate the concept of bad news. Next, we present a brief history of bad news scholarship as it has been treated by both the medical and the social scientific fields. Then, we more fully articulate the bad news delivery process from the perspective of the sender. A brief discussion of candidate theories capable of enlightening the bad news delivery process follows.The chapter concludes with practical suggestions for those faced with breaking bad news.

What Is Bad News?

Most definitions of bad news come from the medical domain. For example, Fallowfield and Jenkins (2004) consider bad news to be "any information that produces a negative alteration to a person's expectations about their present and future" (p. 312). Similarly, Buckman (1984) labels information as bad news if it drastically alters the recipient's views of his or her future. Other authors consider news to be bad if it results in persistent cognitive, behavioral, or emotional deficits in the receiver (Ptacek & Eberhardt, 1996). Objectively defining bad news is problematic because what counts as bad news for one person might not be perceived as bad news by another (Eberhardt-McKee & Ptacek, 2001; Eggly et al., 2006; Fallowfield & Jenkins, 2004; Ptacek & Eberhardt, 1996). The Fallowfield and Jenkins definition seems to capture the lay understanding of bad news in the sense that people do tend to continue labeling a piece of information "news" even when

that information is technically no longer novel (e.g., "I received some bad news earlier this week"). However, this definition might be overly inclusive in the sense that intrapersonally derived information (e.g., a frightening dream resulting in a negative memory) becomes indistinguishable   from news received from an outside source. Ptacek and Eberhardt's (1996) and Buckman's (1984) definitions come closer to reserving the label bad news only for the negative information as it is being conveyed for the first time. Also, this definition reflects the view that the news must be transmitted socially (Eberhardt-McKee & Ptacek, 2001).

In the strictest sense, bad news is receiver defined. Nevertheless, extant definitions of bad news minimally imply that providers perceiving themselves as faced with delivering bad news think, feel, and act in accordance with what they anticipate will constitute bad news for the recipient. Thus, bad news is defined here as *a message communicating information that is assumed to be previously unknown to the receiver, anticipated to be personally relevant to the receiver, and is perceived by the messenger to be negatively valenced by the receiver* (Dibble & Levine, 2010).

Bad news messages can be characterized as varying according to their values on an array of underlying dimensions having to do with the nature of the bad news itself. For example, all bad news messages convey negative information (i.e., the *valence* is negative by definition), but the *extremity* of the message refers to how negative the news is (Sweeny & Shepperd, 2007). That is, there are gradations of bad news (Dibble & Levine, 2010; Fallowfield & Jenkins, 2004). The *involvement* of a message refers to how personally relevant the negative consequences are for the receiver (Rosen & Tesser, 1972). Sweeny and Shepperd (2007) also identify the *controllability* of the negative consequences (from either the sender's or the receiver's perspective), as well as the *likelihood* of the negative consequences actually befalling the recipient, assuming the recipient does not act (or cannot act) to prevent them. Finally, some senders relay bad news for which they are directly responsible, whereas other senders bear negative tidings on behalf of some other responsible party. The party or root stimulus responsible for initiating the negative consequences implied by the bad news message might be fruitfully labeled the *agent* of the consequences of the bad news. Note the agent does not have to be human. In the provider-recipient context, the provider typically relays bad news that he or she did not cause. Thus, the provider is not also the agent. In other situations, however, the sender and the agent will be one in the same (e.g., a provider admitting to a recipient that the provider has made a mistake). When the provider is also the agent, the bad news arrives through self-disclosure. In this way, bad news and self-disclosure do share some conceptual overlap, but not all self-disclosure is bad news, just as not all bad news is self-disclosure.

It is generally assumed that these dimensions influence the specific experience of providers who are faced with delivering bad news (Sweeny & Shepperd, 2007). To provide an example, consider the situation of a physician who prepares to reveal a terminal cancer diagnosis to a patient. This situation will no doubt be fairly extreme for the patient. Involvement is also high in that this particular diagnosis gets assigned to this particular patient. Further, there is nothing the patient can do to avoid the terminal cancer. Thus, controllability may be low. Finally, in this particular example, the agent of the negative consequences may actually be ambiguous. The cancer might have developed due to any number of causes (e.g., poor diet, smoking, lack of exercise, genetics). To the extent that these causes are known, the agent of the negative consequences brought by the diagnosis can be identified. Regardless, to the extent that the physician anticipates the situation characterized by a given pattern of values on these dimensions, his or her communication with the patient will be markedly different than if he or she anticipated a different configuration of dimension values (e.g., relaying news of a cancer that is relatively easy to treat).

History of Bad News Scholarship

Scholarship on the bad news delivery process is typically carried out within two broad domains. First, the medical domain is probably the largest producer of scholarly writing on bad news delivery. This makes sense given the frequency with which medical caregivers have to reveal bad news. The second domain where bad news research is conducted is the social sciences, particularly the fields of communication and social psychology. This section discusses the work of each domain in turn.

Medical Scholarship on Bad News Delivery

Physicians and other healthcare providers routinely find themselves in the position of having to deliver bad news to patients and care recipients. Thus, it is not surprising to find much writing on the topic of breaking bad news in the medical literature. Articles addressing bad news abound in many types of medical and health-oriented journals, ranging from general practice guidelines (Baile et al., 2000) to more localized specialties such as oncology (Back et al., 2008; Cherney, 2010; Spiegel et al., 2009; Walling et al., 2008; Yun et al., 2010), breast imaging screening (Adler, Riba, & Eggly, 2009; van Vliet et al., 2011), children's hearing loss (Gilbey, 2010), and genetic counseling (e.g., Adelsward & Sachs, 2003; McAllister, Dunn, & Todd, 2010; McAllister et al., 2007), to name a few.

Traditional writing on bad news delivery emerging from the medical fields is offered as instruction to healthcare providers about how to "best" break bad news to their recipients in ways that maximize the recipient's benefit (Ptacek & Eberhardt, 1996). As others have noted (Eggly et al., 2006; Harrison & Walling, 2010), healthcare provider guidelines tacitly assume that the bad news delivery process is linear, and that providers should expect the process to unfold in three broad phases. First, providers should prepare for the bad news encounter by securing an appropriate location, earmarking adequate time for the interaction, and so forth. Second, providers should disclose the news using simple language, monitor the pace of delivery, and verify that the recipient has understood. Third, once the bad news has been delivered, providers should allow for and then respond to the recipient's reactions, answer questions, and point out the future course(s) of action. For example, the SPIKES protocol (Baile et al., 2000; see also Amason, Horvath, & Smith, this volume) continues to be highly cited and regarded as a straightforward method of disclosing unfavorable information. SPIKES is an acronym describing the bad news delivery process as comprising six stages: [S]etting up the interview, assessing the patient's [P]erception, obtaining the patient's [I]nvitation, giving [K]nowledge and information to the patient, addressing the patient's [E]motions with empathic responses, and [S]trategy and summary. Other similar mnemonics have been developed (e.g., ABCDE, Vandekieft, 2001).

Some articles are beginning to report tests of the effectiveness of such recommendations. For example, Bruera and colleagues (2007) used videorecorded sequences of physicians delivering cancer diagnoses to determine whether patients preferred a sitting or standing physician. They found that sitting was preferred, but that posture was less important than other communication behaviors. Other articles report tests of communication skills training workshops for residents (e.g., Back et al., 2007; Brown & Bylund, 2008; Lienard et al., 2010; Schildmann, Kupfer, Burchardi, & Vollmann, 2011), and the use of simulated interviews to teach medical students how to reveal cancer diagnoses (Supiot & Bonnaud-Antignac, 2008).

Not surprisingly, the overwhelming focus of these articles is to instruct providers on the best ways to break bad news for *the recipient's benefit*. Interestingly, although the authors of SPIKES acknowledged the costs incurred by the bearers of the bad news, the protocol only indirectly addresses these costs vis-à-vis the use of a standard protocol for the patient's satisfaction. In a sense, the implication of this and similar approaches is that satisfied recipients equal satisfied providers. Put differently, delivering bad news would otherwise be a simple matter if the recipient's emotions could somehow be managed. As is shown later, however, the recipient's emotionality is not the only motivator of the hesitation to share bad news.

It is the notion that other motivations drive providers' uneasiness with breaking bad news that is only recently beginning to reach providers. Thus, articles about bad news between providers and recipients are now emerging that attempt to revise the view that breaking bad news can even be considered a straightforward duty (Eggly et al., 2006; Villagran, Goldsmith, Wittenberg-Lyles, & Baldwin, 2010; Whitney, McCullough, Fruge, McGuire, & Volk, 2008). More is discussed on this issue later. Now, our attention turns to the other domain where bad news research is conducted.

Social Scientific Scholarship on Bad News Delivery

Compared to the work from the medical domains, social scientific research appears to be following a different trajectory. Here, researchers concern themselves with the variables that influence the sender's hesitation to share bad news. Since Rosen and Tesser's (1972) early work more than four decades ago, social scientists have documented the hesitation to share bad news in a variety of settings, and they have conducted scores of experiments to identify the factors that influence this reluctance to break bad news. Because social science has uncovered much about this process since the 1970s, we devote the entire next section to discussing these findings.

The most common finding in social scientific bad news research is that people are hesitant to share bad news. This hesitancy reflects a systematic bias in interpersonal communication that Rosen and Tesser (1972) referred to as the MUM effect (MUM being an acronym for keeping [M]um about [U]ndesirable [M]essages). The MUM effect reveals itself in various forms and across diverse settings. For example, senders have been found to delay the negative information (Bond & Anderson, 1987; Dibble & Levine, 2010; Tesser, Rosen, & Tesser, 1971; Yariv, 2006), distort or downplay the negativity of the message or its consequences (Fisher, 1979), or opt for less immediate channels of bad news delivery (e.g., e-mail, Sussman & Sproull, 1999). The example given at the beginning of the chapter when physicians delayed dementia diagnoses for up to two years (Paterson & Pond, 2009) might represent one manifestation of the MUM effect. Other settings in which the MUM effects have been documented include supervisor-subordinate communication (e.g., Wagoner & Waldron, 1999; Yariv, 2006), between coworkers (Bisel, Kelley, Ploeger, & Messersmith, 2011), and between college student peers (Dibble & Levine, 2010; Weenig, Wilke, & ter Mors, 2011).

Tesser and Rosen (1975) considered the MUM effect to be multicausal, and they detailed three categories of possible causes. The first collection of explanations argues that MUM effects result because of sender *self-concerns*. For example,

senders might prefer to avoid feeling guilty (especially if they do not share the receiver's fate), senders might fear being evaluated negatively by the receiver, or senders might wish to avoid adopting a mood congruent with the tone of the tidings they bear. The second group of explanations proposes situations where senders are reluctant to share bad news out of a concern for the *receiver*. For example, senders may wish to avoid upsetting the receiver, or they may believe receivers do not wish to hear bad news (as opposed to good news). Most medical bad news research seems grounded within these concern-for-receiver explanations. The third category of explanations concerns the *social norms* surrounding bad news transmission. For example, MUM effects might emerge because senders prefer to adhere to some norm that forbids sharing bad news, or because the norms regarding bad news delivery are themselves ambiguous.

Subsequent experimentation has revealed varying support for the hypotheses grouped under each class of concerns, and studies continue to explore the tenability of several of these explanations. The latest research appears to focus on those explanations having to do with concerns about self and concerns about the other. For example, Bond and Anderson (1987) found that the MUM effect they observed was driven less by actual *private* discomfort on the part of the sender and instead reflected a *public* display of contrition. This research suggests that the bulk of the sender's concern was self-directed. Dibble (2008) hypothesized that having to share bad news with a close friend (as opposed to a stranger) might trigger a situation in which concerns for the other outweigh self-concerns. The data were more consistent with Bond and Anderson's (1987) findings regarding self-directed concerns.

The latest social scientific research on bad news delivery appears to be following two lines. First, the nature of the temporal delay before senders begin the onset of their bad news messages is being explored (e.g., Dibble & Levine, 2010; Dibble et al., 2011). A series of experiments is under way to determine whether the delay is but an incidental artifact of having to plan a negative message or if instead the delay might contain communicative value. If this delay serves as a communication stimulus (effected consciously or otherwise), it might be a nonverbal cue meant for the receiver. In this way, the delay might function as a sort of "warning shot," foreshadowing the valence of the forthcoming news. Determining the nature of this delay holds implications for providers who seek alternate ways to soften the blow of bad news.

The second line of inquiry takes a more global approach. Weenig, Wilke, and ter Mors (2011) are integrating the bad news literature with the literature on rumors in the service of developing a general theory of news sharing. They noted

that not *all* bad news is shared with the expected reluctance. In some situations, they posited, people might share bad news even more rapidly than comparable good news. Weenig, Wilke, and ter Mors found the relationship between news valence and reluctance to be moderated by three variables: the extent to which the negative consequences are uncertain, the extent to which the sender shares the receiver's fate, and the closeness of the relationship between the sender and receiver. Contrary to typical MUM findings, they argued that what they call "black rumors" might represent a kind of bad news where the combination of fate uncertainty, fate similarity, and relationship closeness is such that senders might not hesitate to spread the news.

Considering the individual hypotheses already generated to explain the MUM effect (e.g., self-presentation concerns, concern for receiver's feelings), a link to face concerns is plain. Indeed, casting the hesitation to share bad news as a public self-presentation display (Bond & Anderson, 1987; Uysal & Oner-Ozkan, 2007) automatically calls to mind concerns about face. What follows next is a discussion of the need for theory with regard to the bad news delivery process, as well as relevant communication-based approaches that may facilitate an investigation of the face threats associated with delivering bad news.

Candidate Theories to Illuminate Bad News Delivery

The time has come for bad news research to move beyond experimental MUM effect demonstrations toward theoretical development. Fortunately, work has begun in this area. This section discusses three theories that hold potential to inform the bad news delivery process between providers and recipients. As will be seen, none of these theories capture the bad news delivery process in its entirety. Thus, this chapter advocates an eclectic approach that relies on any combination of these (or other) theories based on the portion of the bad news delivery encounter of primary interest. We examine the bad news response model (BNRM), identity implications theory (IIT), and communicative responsibility theory (CRT).

Bad News Response Model

The Bad News Response Model (BNRM) (Sweeny & Shepperd, 2007) emerged to standardize what it means to give bad news successfully, and to assist givers of bad news in guiding recipients toward so-called desired responses. This perspective holds that senders of bad news have as their goal to evoke a desired response in the recipient. According to the BNRM, senders encourage news recipients to respond using watchful waiting (e.g., "wait and see"), active change (e.g., vigorous,

engaged information-seeking), acceptance (e.g., revising one's life to cope with the negative consequences), and/or nonresponse (e.g., denial, disbelief, dismissal). Situational factors, including the controllability, likelihood, and severity of the news, are proposed to influence the sender's choice of which response should be the "desired" response.

As useful as the BNRM (Sweeny & Shepperd, 2007) should be, this model is mute on face threat processes that could mediate the relationship between situational factors and the choice of the desired response. The nature of the face threats involved may explain additional variability in good and bad news sharing not accounted for by bad news message dimensions alone. In other words, it may not necessarily be the characteristics inherent to the bad news that bring about the sender's response, but that these characteristics portend certain face threats that, in turn, influence the sender's goals, affective responses, and communicative actions. Moreover, communication literature reveals that, during any given interaction, individuals often pursue multiple goals (O'Keefe, 1988). Thus, there could be salient goals in addition to the one posed by the BNRM. A communication analysis of the anticipated threats to face and the specific goals pursued benefits investigations of the mechanism through which the types of bad news impact the sender's cognitive, affective, and message production experiences.

Further, the BNRM (Sweeny & Shepperd, 2007) appears to conceptualize face threats too coarsely. The BNRM seemingly takes face threats for granted, as an implicit and monolithic background factor associated with delivering bad news. As Wilson, Aleman, and Leatham (1998) noted, however, threats to the receiver's face are not the only salient face concerns in any given interaction. Thus, the BNRM fails to address the more nuanced view of face threats that has emerged from communication research of late. It is this chapter's position that attending to the finer-grained attributes of face threats is important to understanding the bad news delivery process. We next discuss a theory that holds the potential to augment the BNRM by further articulating the nature of face threats associated with delivering bad news.

Identity Implications Theory

Identity Implications Theory (IIT) (Wilson, Aleman, & Leathem, 1998; Wilson & Feng, 2007) emerged as a revision of politeness theory (Brown & Levinson, 1987). Like politeness theory, IIT also assumes that individuals in interaction with others manage two face desires. First, people prefer to be approved of by others (positive face). Second, people desire to remain free from imposition (negative face). Further, IIT assumes that people typically prefer to consider each other's faces in

interaction (Goffman, 1967). The aim of IIT is to predict a communicator's recognition of face threats based on the communicator's implicit knowledge of (a) the defining conditions for speech acts (Searle, 1969), and (b) the primary goals for interaction. IIT revises the analysis of politeness theory to account for the possibility that several types of face concerns can be simultaneously salient in a given interaction. Unlike politeness theory, IIT assumes that, depending on the situation, both interactants' positive and negative faces can be concurrently and differentially threatened.

As one might expect, the IIT analysis begins by identifying a specific illocutionary speech act of interest (e.g., requests, refusals, criticisms, promises) (Searle, 1969) and then identifying its relevant face concerns. IIT might be fruitfully extended to the context of bad news delivery for at least two related reasons. First, a seemingly indefinite range of speech acts can be regarded as bad news. Because bad news is largely receiver defined, any of a request, denial, assertion, or promise could be construed as bad news. To illustrate, a dentist *requesting* a patient to schedule a dental examination can signal "bad news" for the patient who anticipates that cavities will be discovered. A provider's *denial* of pain medication will no doubt mean "bad news" for the patient in pain. Thus, applying IIT to a larger communication situation might enhance the theory's explanatory reach. Increased analytical efficiency is a companion benefit because IIT would be applied to a collection of speech acts related through their proclivity to count as bad news, instead of single speech acts that have been dissociated from context. Researchers interested less in zero-order speech acts and more in the higher level and context-bound bad news these speech acts convey may appreciate such versatility in a theory.

Second, many communication situations cannot be easily reduced to a tidy and organized collection of individually identifiable speech acts. Human conversation is messy. Thus, successful application of IIT to the situation of delivering bad news would broaden the theory's scope and demonstrate its utility beyond analyses of isolated speech acts.

When leveraged in the case of bad news delivery, the IIT analytical procedures serve to identify the defining conditions for bad news delivery as well as the primary goals of the provider. Individuals often manage multiple and sometimes conflicting goals when interacting with others (O'Keefe, 1988). With respect to goals, the situation of delivering bad news is interesting because a provider can pursue a variety of goals, each involving an information valence that is negative (at least from the receiver's perspective). Thus, the provider who informs a recipient of the decision against issuing a new prescription for pain medication might pursue the primary goal of compliance with regulations. A physician delivering a

cancer diagnosis might be pursuing the primary goal of providing medically necessary information. In both cases, the senders would likely anticipate themselves to be breaking bad news even though their goals were qualitatively different. The negativity of the message and its implied consequences are believed to shade the planning and achievement of the provider's goal(s).

Communicative Responsibility Theory

Communicative Responsibility Theory (CRT) (Aune, Levine, Park, Asada, & Banas, 2005) is a theory of message processing. Essentially, CRT invokes the level of responsibility one perceives for establishing shared meaning to explain the extent to which interlocutors engage in redundancies, conversational implicatures, and inference making during the communication encounter. The provider-recipient bad news encounter is rife with opportunities for implied and indirect communication (e.g., van Vliet et al., 2011). Thus, in the context of delivering bad news there is likely a disproportional distribution of communicative responsibility between the communicators. Consequently, as a provider relays bad news to a recipient, inference making and conversational implicature might be expected to vary in ways specific to that communication situation. Moreover, it is theoretically interesting to document the role of the valence of the news (i.e., its "goodness" or "badness") in the way(s) bad news messages are processed and communicated. The relationship between the bad news context and CRT is therefore one of reciprocal benefit: The bad news delivery context enables a test of CRT, and the application of CRT facilitates a deeper understanding of the communicative mechanisms that underpin the delivery of bad news messages.

Conclusions and Implications

Thus far we have defined bad news, discussed the typical ways bad news delivery has been studied, and presented three theories with the potential to enlighten our understanding of the bad news delivery process. What follows are some practical suggestions for providers based on the research findings to date.

Eggly et al. (2006) summarize nicely several assumptions often associated with breaking bad news in the provider-recipient context. These assumptions are presented here to justify the practical recommendations they inspired. First, as evidenced by the various protocols that abound for bad news sharing, providers should not assume that bad news interactions can be perfectly predicted and, therefore, planned. Recall that bad news is largely receiver defined, and that bad news sharing interactions are intensely variable. For example, Eggly et al. observed

that some patients react to information about participating in a clinical trial with relief, despair, or without any visible cues that would suggest to a provider how the recipient is taking the news. Eggly et al. suggested that instead of attempting to systematize bad news interactions, providers equip themselves for any interaction in which information will be shared, no matter how grave or trivial that information may appear. In this sense, providers do not prepare for a "bad news encounter," per se, but a potentially stressful encounter that may or may not reveal itself to be a bad news interaction. Thus, competent providers assume a more macro approach—one that recognizes the potential for any information to be received as "bad" and, thus, calls for behaviors appropriate to that sensitivity.

The Eggly et al. (2006) data point to a second assumption: Provider-recipient bad news interactions tend to focus on only one central piece of information (e.g., the death of a loved one, the Alzheimer disease diagnosis). To the contrary, provider-recipient encounters often involve multiple pieces of important information (e.g., necessity of further testing, treatment options, risks and consequences associated with various courses of action, clinical trials). An initial diagnosis is no doubt critical, but it is only one piece of a universe of important information that recipients must receive. Thus, focusing one's preparation only on some central piece of information can leave the other important pieces of information laid out with less care. It is incumbent on providers to ensure that recipients comprehend these other details. This is consistent with the call of Duggan and Bradshaw (2008) to boost providers' responsiveness to their recipients. In response, Eggly et al. recommended that providers discuss all pieces of information with the same due diligence as the "central" piece. Thus, just as a physician would relay a cancer diagnosis using lay language, speaking in small chunks, and so forth, he or she should practice the same care with any piece of information, hastening to add repetition of critical material, clear transitions between pieces of information, and clear explanations of how the pieces of information are related. This sentiment is underscored by other researchers (e.g., Gillotti, Thompson, and McNeilis, 2002; McNeilis, 2001), whose data suggest that providers consider the amount of time necessary for the bad news encounter. Depending on the situation, providers might wish to deliver the information over multiple appointments. In this way, the recipient's comprehension and understanding can be checked.

Third and finally, extant bad news sharing protocol appears to operate under the mistaken assumption that bad news encounters are dyadic in nature. In contrast, companions and family members often accompany receivers/patients during these interactions. More to the point, Eggly et al. (2006) found that more information seeking and questions originated from the companions than the patients

themselves! Providers will no doubt already recognize that recipients are often not alone during bad news sharing episodes (Villagran et al., 2010). Unfortunately, little attention is paid to this issue by the current bad news sharing guidelines. Eggly et al. called for more strategies that equip providers to handle encounters with multiple participants. More specifically, when providers ask about prior knowledge, desire for information, understanding, and the like, they should attempt to do so from every participant in the interaction.

The social scientific research conducted thus far inspires practical recommendations that also attend to the well-being of the provider. Dibble and Levine (2010) found that the sender's cognitive and behavioral responses vary concomitantly with the valence of the news (i.e., its "goodness" or "badness"). Specifically, strongly negative news prompted the most reluctance and longest delays, midrange valences prompted moderate levels of reluctance and moderate delays, and strongly positive news prompted little to no reluctance and little to no delay. This finding stresses the importance of the provider's accurate appraisal of the negativity of the bad news. To combine this notion with the assumptions already described by Eggly et al. (2006) reveals a practical suggestion. Providers who wish to avoid unnecessary stress and worry should work to remain acutely sensitive to the recipient's judgments of the news. Errors in appraising the negativity of the news could lead to unnecessary worry, reluctance, and/or—much worse—a miscommunication of information. The work of Weenig et al. (2011) also suggests providers compensate for the relative lack of a close relationship between themselves and the recipient by reducing the cost(s) associated with transmitting the bad news. This might be accomplished through training that teaches providers how to cope with emotional and/or angry reactions from the recipient. Such training serves the additional purpose of helping the provider manage his or her face concerns in that he or she brings the news in a way that will be respected by the recipient.

Any of these suggestions can be admittedly difficult to execute given limited time resources. In choosing to tailor these strategies, however, providers must carefully weigh the costs and benefits of such decisions. What initially appears to be a time saver could instead be a missed opportunity to elicit or provide critical information that might have influenced a subsequent course of action. Competent providers must exercise a great deal of flexibility in their approach(es) to disclosing potentially negative information.

Flexibility is perhaps the competent provider's greatest asset. As we have seen, bad news transactions are anything but a one-size-fits-all process. Bad news encounters are as idiosyncratic as the recipients for whom the providers care. Future guidelines would do well to acknowledge the requirement of flexibility and build

in strategies for teaching providers how to increase their flexibility (Cegala, 2006; Sparks, Villagran, Parker-Raley, & Cunningham, 2007; Villagran et al., 2010). In so doing, providers will be equipped with a much broader and deeper skillset with which to attend to the sensitive situation of breaking bad news.

References

Adelsward, V., & Sachs, L. (2003). The messenger's dilemmas: Giving and getting information in genealogical mapping for hereditary cancer. *Health*, *Risk*, & *Society*, *5*, 125–138. doi:10.1080/1369857031000123911

Adler, D. D., Riba, M. B., & Eggly, S. (2009). Breaking bad news in the breast imaging setting. *Academic Radiology*, *16*, 130–135. doi:10.1016/j.acra.2008.08.006

Amason, P., Smith, C., Romanin, S., & Hovath, M. (2012). Physicians' views of interpersonal communication training, the importance of communication in their medical practices and the delivery of bad news. In B. R. Bates & R. Ahmed (Eds.), *Medical communication in clinical contexts* 169–188. Dubuque, IA: Kendall Hunt.

Aune, R. K., Levine, T. R., Park, H. S., Asada, K. J., & Banas, J. A. (2005). Tests of a theory of communicative responsibility. *Journal of Language and Social Psychology*, *24*, 358–381. doi:10.1177/0261927X05281425

Back, A. L., Anderson, W. G., Bunch, L., Marr, L. A., Wallace, J. A., Yang, H. B. et al. (2008). Communication about cancer near the end of life. *Cancer*, *113*, 1897–1910. doi:10.1002/cncr.23653

Back, A. L., Arnold, R. M., Baile, W. F., Fryer-Edwards, K. A., Alexander, S. C., Barley, G. E. et al. (2007). Efficacy of communication skills training for giving bad news and discussing transitions to palliative care. *Archives of Internal Medicine*, *167*, 453–460.

Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., & Kudelka, A. P. (2000). SPIKES—a six-step protocol for delivering bad news: Application to the patient with cancer. *The Oncologist*, *5*, 302–311. doi:10.1634/theoncologist.5-4-302

Bisel, R. S., Kelley, K. M., Ploeger, N. A., & Messersmith, J. (2011). Workers moral mum effect: On facework and unethical behavior in the workplace. *Communication Studies*, *62*, 153–170. doi:10.1080/10510974.2010.551314

Bond, C. F. Jr., & Anderson, E. L. (1987). The reluctance to transmit bad news: Private discomfort or public display? *Journal of Experimental Social Psychology*, *23*, 176–187.

Brown, P., & Levinson, S. C. (1987). *Politeness: Some universals in language usage*. Cambridge: Cambridge University Press.

Brown, R. F., & Bylund, C. L. (2008). Communication skills training: Describing a new conceptual model. *Academic Medicine*, *83*, 37–44.

Bruera, E., Palmer, J. L., Pace, E., Zhang, K., Willey, J., Strasser, F. et al. (2007). A randomized, controlled trial of physician postures when breaking bad news to cancer patients. *Palliative Medicine*, 21, 501–505. doi:10.1177/0269216307081184

Buckman, R. (1984). Breaking bad news: Why is it still so difficult? *British Medical Journal*, *288*, 1597–1599.

Cegala, D. J. (2006). Emerging trends and future directions in patient communication skills training. *Health Communication*, *20*, 123–129. doi:10.1207/s15327027hc2002_3

Cherney, N. I., & Palliative Care Working Group of the European Society for Medical Oncology. (2010). Factors influencing the attitudes and behaviors of oncologists regarding the truthful disclosure of information to patients with advanced and incurable cancer. *Psycho-Oncology*. Advance online publication. doi:10.1002/pon.1853

Del Vento, A., Bavelas, J., Healing, S., MacLean, G., & Kirk, P. (2009). An experimental investigation of the dilemma of delivering bad news. *Patient Education and Counseling*, *77*, 443–449.

Dibble, J. L. (2008). *On the hesitation to share bad news: Three empirical studies* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database, UMI No. 3331893.

Dibble, J. L., & Levine, T. R. (2010). Breaking good and bad news: Direction of the MUM effect and senders' cognitive representations of news valence. *Communication Research*, *37*, 703–722. doi:10.1177/0093650209356440

Dibble, J. L., Wisner, A. M., Fujimoto, J., Koo, M., Higashi, A., Mendoza, S. et al. (2011). Reluctance to share bad news: Communication stimulus or byproduct of planning a negative message. *Paper presented at the annual meeting of the Western States Communication Association*, Monterey, CA.

Duggan, A. P., & Bradshaw, Y. S. (2008). Mutual influence processes in physician-patient communication: An interaction adaptation perspective. *Communication Research Reports*, *25*, 211–226. doi:10.1080/08824090802237618

Eberhardt-McKee, T., & Ptacek, J. T. (2001). I'm afraid I have something bad to tell you: Breaking bad news from the perspective of the giver. *Journal of Applied Social Psychology*, *31*, 246–273.

Eggly, S., Penner, L., Albrecht, T. L., Cline, R. J. W., Foster, F., Naughton, M., et al. (2006). Discussing bad news in the outpatient clinic: Rethinking current communication guidelines. *Journal of Clinical Oncology*, *24*, 716–719.

Fallowfield, L., & Jenkins, V. (2004). Communicating sad, bad, and difficult news in medicine. *Lancet*, *363*, 312–319.

Fisher, C. D. (1979). Transmission of positive and negative feedback to subordinates: A laboratory investigation. *Journal of Applied Psychology*, *64*, 533–540.

Gilbey, P. (2010). Qualitative analysis of parents' experience with receiving the news of the detection of their child's hearing loss. *International Journal of Pediatric Otorhinolaryngology*, *74*, 265–270. doi:10.1016/j.ijporl.2009.11.017

Gillotti, C., Thompson, T., & McNeilis, K. (2002). Communicative competence in the delivery of bad news. *Social Science & Medicine*, *54*, 1011–1023.

Goffman, E. (1967). *Interaction ritual*. New York: Pantheon Books.

Harrison, M. E., & Walling, A. (2010). What do we know about giving bad news? A review. *Clinical Pediatrics*, 49, 619–626. doi:10.1177/0009922810361380

Lienard, A., Merckaert, I., Libert, Y., Bragard, I., Delvaux, N., Etienne, A.-M. et al. (2010). Is it possible to improve residents breaking bad news skills? A randomized study assessing the efficacy of a communication skills training program. *British Journal of Cancer*, *103*, 171–177. doi:10.1038/sj.bjc.6605749

McAllister, M., Dunn, G., & Todd, C. (2010). Empowerment: Qualitative underpinning of a new clinical genetics-specific patient-reported outcome. *European Journal of Human Genetics*, *19*, 125–130. doi:10.1038/ejhg.2010.160

McAllister, M., Payne, K., Nicholls, S., MacLeod, R., Donnai, D., & Davies, L. M. (2007). Improving service evaluation in clinical genetics: Identifying effects of genetic diseases on individuals and families. *Journal of Genetic Counseling*, *16*, 71–83. doi:10.1007/s10897-006-9046-3

McNeilis, K. S. (2001). Analyzing communication competence in medical consultations. *Health Communication*, *13*, 5–18.

Merker, B. M., Hanson, W. E., & Poston, J. M. (2010). National survey of psychologists' training and practice in breaking bad news: A mixed methods study of the MUM effect. *Journal of Clinical Psychology in Medical Settings*, *17*, 211–219. doi:10.1007/s10880-010-9197-0

O'Keefe, B. J. (1988). The logic of message design: Individual differences in reasoning about communication. *Communication Monographs*, *55*, 80–104.

Paterson, N. E., & Pond, D. (2009). Early diagnosis of dementia and diagnostic disclosure in primary care in Australia: A qualitative study into the barriers and enablers. *Alzheimer's & Dementia*, *5*(5), e15.

Ptacek, J. T., & Eberhardt, T. L. (1996). Breaking bad news: A review of the literature. *JAMA*, *276*, 496–502.

Ptacek, J. T., Ptacek, J. J., & Ellison, N. M. (2001). 'I'm sorry to tell you …' Physician's reports of breaking bad news. *Journal of Behavioral Medicine*, *24*, 205–217.

Rider, E. A., Volkan, K., & Hafler, J. P. (2008). Pediatric residents' perceptions of communication competencies: Implications for teaching. *Medical Teacher*, *30*, e208–e217. doi:10.1080/01421590802208842

Rosen, S., & Tesser, A. (1972). Fear of negative evaluation and the reluctance to transmit bad news. *Journal of Communication*, *22*, 124–141.

Schildmann, J., Kupfer, S., Burchardi, N., & Vollmann, J. (2011). Teaching and evaluating breaking bad news: A pre-post evaluation study of a teaching intervention for medical students and a comparative analysis of different measurement instruments and raters. *Patient Education and Counseling*. Advance online publication. doi:10.1016/j.pec.2011.04.022

Searle, J. R. (1969). *Speech acts: An essay in the philosophy of language*. Cambridge: Cambridge University Press.

Sparks, L., Villagran, M. M., Parker-Raley, J., & Cunningham, C. B. (2007). A patient-centered approach to breaking bad news: Communication guidelines for healthcare providers. *Journal of Applied Communication Research*, *35*, 177–196. doi:10.1080/00909880701262997

Spiegel, W., Zidek, T., Maier, M., Vutuc, C., Isak, K., Karlic, H. et al. (2009). Breaking bad news to cancer patients: Survey and analysis. *Psycho-Oncology*, *18*, 179–186. doi:10.1002/pon.1383

Supiot, S., & Bonnaud-Antignac, A. (2008). Using simulated interviews to teach junior medical students to disclose the diagnosis of cancer. *Journal of Cancer Education*, *23*, 102–107. doi:10.1080/08858190701849437

Sussman, S. W., & Sproull, L. (1999). Straight talk: Delivering bad news through electronic communication. *Information Systems Research*, *10*, 150–166.

Sweeny, K., & Shepperd, J. A. (2007). Being the best bearer of bad tidings. *Review of General Psychology*, *11*, 235–257.

Tesser, A., & Rosen, S. (1975). The reluctance to transmit bad news. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 8, pp. 193–232). New York: Academic Press.

Tesser, A., Rosen, S., & Tesser, M. (1971). On the reluctance to communicate undesirable messages (the MUM effect): A field study. *Psychological Reports*, *29*, 651–654.

Uysal, A., & Oner-Ozkan, B. (2007). A self-presentational approach to transmission of good and bad news. *Social Behavior and Personality*, *35*, 63–78.

Vandekieft, G. K. (2001). Breaking bad news. *American Family Physician*, *64*, 1975–1978.

van Vliet, L., Francke, A., Tomson, S., Plum, N., van der Wall, E., & Bensing, J. (2011). When cure is no option: How explicit and hopeful can information be given? A qualitative study in breast cancer. *Patient Education and Counseling*. Advance online publication. doi:10.1016/j.pec.2011.03.021

Villagran, M., Goldsmith, J., Wittenberg-Lyles, E., & Baldwin, P. (2010). Creating COMFORT: A communication-based model for breaking bad news. *Communication Education*, *59*, 220–234. doi:10.1080/03634521003624031

Wagoner, R., & Waldron, V. R. (1999). How supervisors convey routine bad news: Facework at UPS. *Southern Communication Journal*, *64*, 193–210.

Walling, A., Lorenz, K. A., Dy, S. M., Naeim, A., Sanati, H., Asch, S. M. et al. (2008). Evidence-based recommendations for information and care planning in cancer care. *Journal of Clinical Oncology*, *26*, 3896–3902. doi:10.1200/JCO.2007.15.9509

Weenig, M. W. H., Wilke, H. A. M., & ter Mors, E. (2011). Personal outcomes and moral responsibility as motives for news transmission: The impact of fate similarity, fate uncertainty, and relationship closeness. *Communication Research*. Advance online publication. doi:10.1177/009365021140219

Whitney, S. N., McCullough, L. B., Fruge, E., McGuire, A. L., & Volk, R. J. (2008). Beyond breaking bad news: The roles of hope and hopefulness. *Cancer*, *113*, 442–445. doi:10.1002/cncr.23588

Wilson, S. R., Aleman, C. G., & Leatham, G. B. (1998). Identity implications of influence goals: A revised analysis of face-threatening acts and application to seeking compliance with same-sex friends. *Human Communication Research*, *25*, 64–96.

Wilson, S. R., & Feng, H. (2007). Interaction goals and message production: Conceptual and methodological developments. In D. Roskos-Ewoldsen & J. Monahan (Eds.), *Communication and social cognition* (pp. 71–95). Mahwah, NJ: Lawrence Erlbaum Associates.

Yariv, E. (2006). 'Mum effect': Principals' reluctance to submit negative feedback. Journal of Managerial *Psychology*, *21*, 533–546.

Yun, Y. H., Kwon, Y. C., Lee, M. K., Lee, W. J., Jung, K. H., Do, Y. R. et al. (2010). Experiences and attitudes of patients with terminal cancer and their family caregivers toward the disclosure of terminal illness. *Journal of Clinical Oncology*, *28*, 1950–1957. doi:10.1200/JCO.2009.22.9658