A PIECE OF MY MIND

Breaking Good

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Today's medical literature sometimes offers tips to physicians on how to give bad news.[1,2] Most of us know that giving bad news isn't easy. In medicine, it can be a make-or-break process in the evolution of patient-physician relationships. But what we don't often see in medical literature is advice on giving good news.[3] I learned recently—twice in the same day—that giving even good news can be difficult.

As a radiation oncologist, every day I inform patients they have cancer: the ultimate bad news. I found out what it's like to be on the other side when, during a routine checkup, my own physician laid the bad news on me: the blemish on my face looked like melanoma. A surgeon took the obligatory biopsy, and the torturous wait for test results began.

Slightly more than a week later, the pathologist called with her verdict. "Good news," she announced. "You don't have melanoma. It's only a lentigo." I exhaled. "Please call if you have questions," she said, then hung up before I had a chance to ask any.

Not cancer! I felt elated. But also perplexed: Was it solar lentigo or lentigo maligna? Both typically precede the serious type of skin cancer known as melanoma, but there are vast differences—solar lentigo stays put, lentigo maligna can turn into an invasive melanoma. Which did I have? She did not say. Should I have deduced from her introductory "Good news!" that it was the more favorable variant?

The question, I admit, was unfair. Two reasons. First, my very competent colleague surely assumed that, as a cancer specialist, I would know that when a physician says "lentigo" and nothing more, it indeed serves as code for solar lentigo. Second, I had used my professional influence to expedite the specimen transfer from the dermatologist who had screened me to the pathologist charged with interpreting my test results. In my haste to discover the outcome, I'd bypassed the system. I'd cut out the "middle man"—my family physician—and sought my answer directly from the pathologist, a type of a physician not accustomed to communicating directly with patients. In doing so, I'd assumed that the pathologist would embrace the role of sharing good news and would want to explain in detail. Not necessarily so, I now realize. Instead, a gap in communication tarnished my joy.

That same afternoon, I saw a patient whom I'd treated 10 years earlier for a tiny breast cancer. Her HMO had sent a memo explaining that because she had been disease free for a decade, only one physician could be reimbursed for her care in the future. At our weekly case conference, we agreed that the "one physician" should be her surgeon, so this was to be the patient's final visit with me. After I examined her, I explained the consensus that she had achieved cure. I anticipated a smile, maybe even a hug. Instead, my words unsettled her. "Who will provide follow-up care?" she asked. "Where will I turn for support?"

Just as with my own pathologist, we'd stumbled through what should be the easy part. I was trying to give good news, and my patient was trying to receive it, but the transmission was garbled. She worried about abandonment, and I hadn't prepared her for the disengagement.

She was alarmed and visibly shaken. I didn't have the heart to tell her I'd be stepping out of the picture. Instead, I scheduled her next appointment and, later, instructed the receptionist to put her on my pro bono list.

We sometimes hear of "bad news bias" associated with the media. On several websites devoted to ethics in journalism, I read, "Good news is boring and usually doesn't photograph well." My guess is that patients with cancer could use a little more of that boredom.

Physicians, especially we cancer docs, are called upon regularly to deliver bad news, and even train for it. It should be easy to excel at good-news conversations, since both sides ought to be happy. Physicians crave these opportunities, yet seem afraid of them, since we don't really know what to say or how to say it.

For instance, good news in medicine is often nuanced, maybe even ambiguously accompanied by a dark side. What I mean is that good news from physicians often arrives with caveats. In my case, for example, I don't have a melanoma—phew!—but because I do have a precursor called lentigo, I must commit to rigorous skin screening for the rest of my life.

And what about the logistics of giving good news? Is it necessary to have in-person communication with eye contact? Is it OK to transmit the information by phone, e-mail, or even social media? If we agree that good news should be offered face-to-face, then how do we physicians pick up on the patient's body language? How can we detect signs of impending euphoria or symptoms of invincibility that could lead to potentially dangerous or irresponsible behavior? What if, perhaps like someone receiving compliments, a patient doesn't know how to handle the information? Should we be on guard for a new set of anxieties, as I saw in my patient?

In my specialty, we deal in the best and worst of news, matters literally of life and death. Trying to communicate in the most challenging moments is like practicing extreme sport, so physicians must prepare for both the joy ride and the possibility of a fatal crash. Perhaps the process would feel less daunting if we resolved that it is not just about techniques of delivering bad or good news. It is about wanting to do it in the first place; wanting to participate in another person's life with information that matters.

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A patient recently complained to me that her oncologist never called to let her know her test results. After three weeks, she finally called him. When I asked my associate about it, he said, "As a matter of policy, I call back only if results are abnormal." Did he inform the patient of policy? Did he tell her on what date, if she hadn't heard, she might stop feeling concern? I found this "policy" to be not only insensitive toward patients but also self-defeating for physicians. They forfeit opportunities to savor positive moments, reduce risk of burnout, and capture professional highs.

Giving good news can also be a make-or-break process in the evolution of patient-physician relationships and it, too, isn't easy. As we return to the long-neglected emotional underpinnings of medicine, our profession will achieve new insights into the science of communicating.[4] The good news is we're learning. Now the question: how do we communicate that good news so that all can clearly hear?

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2. Liénard A, Merckaert I, Libert Y, et al. Is it possible to improve residents breaking bad news skills? a randomised study assessing the efficacy of a communication skills training program. *Br J Cancer*. 2010;103(2):171-177.

3. Farrell L. Breaking good news. *BMJ*. 2012;345:e7355.

4. Kissane DW, Bylund CL, Banerjee SC, et al. Communication skills training for oncology professionals. *J Clin Oncol*. 2012;30(11):1242-1247.

The main idea in golf as in life, I suppose, is to learn to accept what cannot be altered, and to keep on doing one's own reasoned and resolute best whether the prospect be bleak or rosy.

Bobby Jones (1902-1971)