Breaking bad news is a mandatory provision in the professional life of nearly every physician. One of its most frequent occasions is the diagnosis of malignancy. Responding to the recipients’ emotions is a critical issue in the delivery of unsettling information, and has an impact on the patient’s trust in the treating physician, adjustment to illness and ultimately treatment. Since the World Health Organization (WHO) declared COVID-19 a pandemic on March 11, 2020, several measures of social distancing and isolation have been introduced to our clinical setting. In the wake of these restrictions, it is important to reexamine existing communication guidelines to determine their applicability to face-to-face counseling in the context of social distancing, as well as to new communication technologies, such as telemedicine. We address these issues and discuss strategies to convey bad news the most empathetic and comprehensible way possible.

Keywords
Breaking bad news · COVID-19 · Social distancing

Dear Editor,

Breaking bad news is a necessary competency for nearly every physician. Life-altering events, like the diagnosis of malignancy, can be associated with various emotions like shock, fright, sadness, or reactions of avoidance, denial, or dissociation [1, 2]. Responding to such emotions is important when delivering unsettling information and has an impact on the patient’s trust in the physician, adjustment to illness, and treatment [3–6].

Under the current COVID-19 pandemic, several measures of social distancing and isolation have been introduced to our clinical setting and make it mandatory to reevaluate current communication in face-to-face counseling under the burden of social distancing, as well as towards new communication technologies, such as telemedicine.

Restrictions of visitors

The involvement of family members or friends plays a critical role for many patients and within established guidelines for breaking bad news. Such persons not only provide emotional support but also help patients capture critical information [7–10]. Furthermore, the aftermath of miscommunication has been associated with various detrimental consequences, such as decreased adherence to clinician recommendations, greater psychological distress, and increased social withdrawal [3, 4, 11]. Restrictions of supportive persons may augment patients’ cognitive, behavioral, or emotional difficulties while receiving bad news.

To counteract, we emphasize the importance of alternative strategies to involve supportive persons in any clinically relevant discussions. Telecommunication devices (e.g., phone or video conferencing) allow patients’ support personnel to participate in these conversations despite physical absence. Additionally, alternative meetings in the immediate surroundings of the hospital can provide a valuable extension for the overall support of the patient.

Extending the support-network by involving a nurse, social worker, chaplain, or psychologist in the communication may here be even more important than it was in non-pandemic times. Furthermore, given that some patients perceive greater empathy in the process of a bad news disclosure from their general practitioner [12], involving the patient’s family doctor may improve difficult conversations in hospital settings.
Generally, it is important to evaluate the patient’s understanding of what is being discussed. Audio or video recordings, which have been shown to improve patients’ ability to recall information during physician-patient consultations [13], represent important supportive tools for the patient. Lastly, it is essential to assess the patient’s understanding of the current restrictions in advance and adapt the setting accordingly.

**Restrictions of physical contact**

Most patients prefer that bad news be given in person and without physical barriers [14–16]. Positioned close to the patient, the bearer of bad news can more easily respond to emotional cues, for example, by touching the patient’s arm or hand if appropriate [17]. Indeed, research has shown that physical contact during such situations can have a positive effect on the patient [15, 18]. Restrictions of physical contact and distance make it more difficult for healthcare providers to respond to patients’ emotions in an empathetic, compassionate way.

However, when explicitly pointed out by the physician as a precautionary measure due to the pandemic, such actions are less likely to be perceived as unfriendly and patients may recognize such words as a sign of solidarity. Such restrictions also hold the opportunity for doctors and patients to relate to one another under the pandemic. This can have a beneficial impact on the relationship and patient outcomes, as confiding communication has been associated with better patient care and adjustment to illness and treatment [3–6]. Therefore, we propose that physicians start conversations by making a short encouraging statement regarding current restrictions in the local clinical setting. Additionally, by asking how he or she is dealing with the pandemic situation, the physician may learn about the patient’s personal circumstances before opening the main dialogue. This may give an indication of the patient’s preferred level of comprehensiveness of information and ability to cope with the upcoming news, two factors that may vary substantially [5, 19, 20]. Besides all these interpersonal aspects, a friendly, non-technical ambience (e.g., pictures, plants) may help to distract from the restriction measures.

**Restrictions of countenance**

Facial masks, worn by both patients and healthcare providers [21], preclude a significant portion of facial expressions. Researchers have argued that 93% of communication consists of nonverbal cues such as facial expressions, gestures, and body movement [22]. Nonverbal communication is particularly important in conveying emotions and has a decisive impact on how individuals perceive and interpret the message [23]. Facial expressions, as well as gestures like posture, nodding of the head, and movement of the extremities, provide patients with information on physicians’ interest and empathy [24]. Restrictions of countenance can therefore make it more difficult for the physician to convey warmth, reassurance, and compassion. Given the importance of compassion in patient-centered communication [25, 26], restrictions may affect not only the doctor-patient relationship but also the adherence and therapeutic outcome. According to our observation, current restrictions of facial expression led to a shift of increased gesticulation, especially hand movements, by the bearer of bad news. Furthermore, complementing a more structured communication-style with open-ended questions may be reinforced by an inviting gesture to the patient. A conscious use of such gestures can reflect empathetic intention, support the lead of the conversation (i.e., hand the word over to the patient and take it back), and help the patient interpret the content of the verbal message. In turn, patients may feel encouraged to use gestures themselves.

Mutually, covered facial expressions of the patient make it difficult for the physician to respond adequately to the patient’s emotions and make patient-centered communication more challenging. Therefore, it is important to verbally address patients’ emotions, for example, to promote disclosure of their concerns or goals for care [27].

| Table 1 | Guidance to optimize breaking bad news to patients under isolation measures |
|---------|--------------------------------------------------------------------------------|
| 1. Minimize disruptive factors in the clinical setting that could hamper the delivery of bad news (e.g., turn off cellphones, sign-out beeps). |
| 2. Use shared affection regarding the isolation measures to strengthen mutual trust and to learn about the patient’s personal circumstances. |
| 3. Deliberately focus on verbal skills to reinforce interest in the patient’s needs (e.g., via verbal connection statements). |
| 4. Emphasize exploratory questions to elaborate on the patient’s emotions and to verify his or her understanding of the conveyed information. Optionally: meet the patient through video conferencing to ensure non-verbal communication via facial expressions. |
| 5. Use alternative non-verbal signals, such as hand movements, to reflect your empathic intent, support the lead of the conversation and help the patient in understanding the actual content of the verbal message. |
| 6. Take advantage of a nurse, social worker, religious personnel, psychologist, or audio recording for the patient in the absence of close relatives or friends. |
| 7. Foster remote integration of patient’s relatives, friends or other key people (e.g., his/her general practitioner) by phone and video conferencing or alternative meetings in the immediate surroundings of the hospital. |
| 8. Create a friendly, non-technical ambience (e.g., pictures, plants) which may help to distract from the restriction measures. |
Conclusion

Under the COVID-19 pandemic, the burden of breaking bad news to cancer patients has become even more challenging than it was in non-pandemic times. Physicians should emphasize thorough preparation of the consultation setting, minimize disruptive factors, and consider the aforementioned caveats and strategies as mentioned above and in the corresponding table (Table 1).

While originating from a hospital setting and in the light of the current pandemic, our article holds implications adaptable to many in- or outpatient clinical scenarios containing isolation measures.

References

1. Schofield PE, Butow PN, Thompson JF, Tattersall MHN, Beeney LJ, Dunn SM (2003) Psychological responses of patients receiving a diagnosis of cancer. Ann Oncol 14(1):48–56
2. Vos MS, de Haes JCJM (2007) Denial in cancer patients, an explorative review. Psychooncology 16(1):12–25
3. Haskard Zolnierek KB, DiMatteo MR (2009) Physician communication and patient adherence to treatment: a meta-analysis. Med Care 47(8):826–834
4. Johnson J, Panagioti M (2018) Interventions to improve the breaking of bad or difficult news by physicians, medical students, and interns/residents: a systematic review and meta-analysis. Acad Med 93(9):1400–1412
5. Marschollek P, Bąkowska K, Bąkowski W, Marschollek K, Tarkowski R (2019) Oncologists and breaking bad news—from the informed patients’ point of view. The evaluation of the SPIKES protocol implementation. J Cancer Educ 34(2):375–380
6. Fallowfield L, Jenkins V (2004) Communicating sad, bad, and difficult news in medicine. Lancet 363(9405):312–319
7. Kulik JV, Desureault S, Quinn G (2012) Teaching medical students how to break bad news with standardized patients. J Cancer Educ 27(2):277–280
8. Sep MSC, van Osch M, van Vliet LM, Smets EMA, Bensing JM (2014) The power of clinicians’ affective communication: how reassurance about non-abandonment can reduce patients’ physiological arousal and increase information recall in bad news consultations. An experimental study using analogue patients. Patient Educ Couns 95(1):45–52
9. Jansen J, van Weert JCM, de Groot J, van Dulmen S, Heeren TJ, Bensing JM (2010) Emotional and informational patient cues: the impact of nurses’ responses on recall. Patient Educ Couns 79(2):218–224
10. Gabriël S, Grize L, Helfenstein E, Brutsche M, Grossman P, Tamm M, Kiss A (2008) Receiving the diagnosis of lung cancer: patient recall of information and satisfaction with physician communication. J Clin Oncol 26(2):297–302
11. Molina Y, Beresford SAA, Espinoza N, Thompson B (2014) Psychological distress, social withdrawal, and coping following receipt of an abnormal mammogram among different ethnicities: a mediation model. Oncol Nurs Forum 41(5):523–532
12. Spiegel W, Zidek T, Maier M, Vutuc C, Isak K, Karlic H, Micksche M (2009) Breaking bad news to cancer patients: survey and analysis. Psychooncology 18(2):179–186
13. van der Meulen N, Jansen J, van Dulmen S, Bensing J, van Weert J (2008) Interventions to improve recall of medical information in cancer patients: a systematic review of the literature. Psychooncology 17(9):857–868
14. Dias L, Chabner BA, Lynch TJ, Penson RT (2003) Breaking bad news: a patient’s perspective. Oncologist 8(6):587–596
15. Creagan ET (1994) How to break bad news—and not devastate the patient. Mayo Clinic Proc 69(10):1015–1017
16. Ptacek JT, Eberhardt TL (1996) Breaking bad news: a review of the literature. JAMA 276(6):496–502
17. VandeKieft G (2001) Breaking bad news. Am Fam Physician 64(12):1975–1978
18. Sparks L, Villagran MM, Parker-Raley J, Cunningham CB (2007) A patient-centered approach to breaking bad news: communication guidelines for health care providers. J Appl Commun Res 35(2):177–196
19. Kudelka P, Baile WF, Buckman R et al (2000) SPIKES—a six-step protocol for delivering bad news: application to the patient with cancer. Oncologist 5(4):302–311
20. Bousquet G, Orri M, Wintener S, Brugière C, Verneuil L, Revah-Levy A (2015) Breaking bad news in oncology: a metasynthesis. J Clin Oncol 33(22):2437–2443
21. Bern IGA 3010. Coronavirus Maskenpflicht Patienten [Internet]. [cited 2020 Jun 8];Available from: https://www.insel.ch/de/patienten-und-besucher/coronavirus/
22. Borg J (2009) Body Language: 7 easy lessons to master the silent language. FT Press, Upper Saddle River
23. Besson C, Graf D, Hartung I, Kropffhäuser B, Voisard S. The importance of non-verbal communication in professional
interpretation [Internet]. aiic.net, 2005 [cited 2020 Jun 19]; Available from: //aiic.net/page/1662

24. Berman AC, Chutka DS (2016) Assessing effective physician-patient communication skills: “Are you listening to me, doc?” Korean J Med Educ 28(2):243–249

25. Maynard DW (1996) On “Realization” in everyday life: the forecasting of bad news as a social relation. Am Sociol Rev 61(1):109–131

26. Morse J (2011) Hearing bad news. J Med Humanit 32(3):187–211

27. Adams K, Cimino JEW, Arnold RM, Anderson WG (2012) Why should I talk about emotion? Communication patterns associated with physician discussion of patient expressions of negative emotion in hospital admission encounters. Patient Educ Couns 89(1):44–50

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