

## CHAPTER TWELVE

## Careful Communication of 'Bad News': The Cancer Experience

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The term 'careful' applies to three different objects or areas of interest within the context of the communication of 'bad news': being careful with the content of what is said, being careful with the person to whom the information is delivered, and finally being careful with oneself when having delivered bad news. The first two aspects will be dealt with in this article, with the hope that the experience gathered in the delivery of bad news in cancer care might extend to the delivery of genetic information.

Taking care, first of all, means avoiding harm (*primum nil nocere*). Therefore, the question is whether there is anything potentially 'delicate' or even harmful in giving information about a cancer diagnosis or about the hopeless condition of a patient. Every physician has had the experience that no matter how carefully he has picked his words, the effect of the news he has delivered seems to be disastrous: patients – and relatives – reacting with intense negative emotions, claiming that this news has destroyed all their hope, may leave one doubting whether telling the truth should be as high a goal as avoiding harm. One might say the major risk that lies in knowledge of the 'truth', i.e. the statistically most likely course of a disease, is its potential to destroy illusions. This can, indeed, be viewed as a risk when illusions are to some extent supportive, for example when they keep an individual going in the hope (perhaps illusory) that an improvement can be achieved. Arguing in this way means accepting that the degree of individual freedom that is based upon the knowledge of one's own condition is given a lower priority than the integrity of unrealistic hopes. In clinical practice, however, such an argument is not well supported: even though an immediate negative reaction to bad

news sometimes occurs, it often transforms to an active, information-seeking position, even within the first session. Patients – often faster than relatives – regain their composure and start asking for concrete details, like whether they will experience pain or shortness of breath, or how long is it going to take. As the ‘truth’ in a given clinical situation is usually complex and laden with insecurity, it is necessary to communicate the most relevant information appropriate to the moment. Especially in a situation when there is little realistic chance that the patient is going to recover, or when it seems likely that he or she is going to die within a few weeks, one of the most difficult issues still remains to achieve a balance between telling the truth (being honest) and leaving room for hope (Surbone 2006, 56 ff.).

On the other hand, leaving illusions in place by not providing information is, in itself, harmful because illusions are often misleading, and may lead to consequences that prevent an individual from making an appropriate choice that matches his or her actual situation. It can easily be seen from these few remarks that patients with conditions difficult or impossible to treat represent a group of individuals for whom it may be extremely challenging to define general rules about the risks and benefits of telling the truth or maintaining ‘protective’ illusions. This is all the more complicated by the fact that patients have no prior experience of receiving a diagnosis of their own fatal disorder and are confronted by a very threatening and unfamiliar situation. Thus, both the healthcare professional providing the information and the receiver of this information constantly have to work on the best way to process this sensitive information. Despite the formidable complexities, there are some data in the literature that – though not defining definite rules – characterize the range of professional behaviours and common patient responses and needs.

The first section of this article will quote some landmark studies reporting on common experiences of patients and professionals in breaking bad news, the second section will develop and discuss suggestions for professional behaviour, and the third section will propose some additional suggestions, based upon contributions from Neo-Phenomenology, as developed by the German philosopher Hermann Schmitz. In my view Schmitz's thinking has the potential to broaden our perspectives on appropriate communication in difficult clinical situations (for an overview see W. Langewitz 2007). Schmitz coined a different definition of the term 'situation', referring to a certain mode of being in which meaningfulness cannot be ascribed to particular observations but is dissolved in variety (Schmitz 2005a, 56 ff.). Situations are opposed to constellations – an arrangement of facts in time and space that, although possibly very complex, can be deduced to single observable and countable units. Furthermore, he describes personal feelings as similar to weather phenomena, e.g. the tense and heavy climate inside a room when there is trouble brewing. In this way, feelings are no longer the exclusive affair of an individual shielded from the environment, but open out into the environment, taking on the quality of an atmosphere poured into a rimless room (Schmitz 2007, 23 ff.). If this holds true, two individuals may jointly partake of a specific situation not only by the exchange of factual information, but also by sharing a common atmosphere. As physicians, we have been trained to convert a situation into a constellation as quickly as possible, protecting us from the invasiveness of feelings as atmospheres and 'sticking to the facts'. According to Schmitz, the receptive organ responsive to atmosphere is the felt body (Leib), as opposed to the corporeal body (Körper). Whereas the surface of the corporeal body can be touched and seen, the felt body can only be perceived in the region of the corporeal body without the use of the senses. If we would allow ourselves as professionals to immerse in mutual embodiment

within a 'situation', we might be better able to adjust our behaviour to the present status of our patients.

### **What Is already Known**

Instead of yet another literature review (a recent review can be found in Surbone 2006), a selection of papers will be referred to below that represent the most recent developments in communication research in cancer care. There have been a number of recent studies that investigate the opinion of patients and relatives concerning the communication of bad news in cancer care. Even though this is certainly to be preferred to statements from experts who are not victims of bad news themselves, this approach is not free of methodological problems, which will be alluded to later in this article.

In a large study by Kaplowitz et al. (2002) 352 out of 1576 cancer patients responded to a questionnaire sent by mail; 83% were female, 63% of all respondents suffered from breast cancer, and over 90% were white. The results showed that 80% of the patients wanted qualitative or more general information (e.g. a response to the question, is the patient probably going to die from his or her case of cancer?); 66% indicated that they had actively asked for it, and 89% actually received qualitative information of this kind. Concerning quantitative or specific prognostic information (e.g. how long the patient is expected to live), results were different: only 53% indicated that they wanted this information, 35% reported having directly asked for it, and 30% said that they had actually received quantitative information.

Another interview study examined how parents of children suffering from cancer wished to be informed (Mack et al. 2006). Results showed that the majority of parents desired as much information about prognosis as possible (87%), and wanted it expressed numerically (85%). More than a third of parents found information about their children's prognosis very upsetting (36%), yet they still wanted this information to

be given – even more so than parents who felt less upset by the information they had received. Furthermore, parents who found information upsetting were no less likely to say that knowing prognosis was important, that knowing prognosis helped in decision making, or that hope for a cure kept them going. Thus, it does not seem wise to accept avoidance of upsetting the receiver of information as the ultimate goal of providing information; the upsetting nature of prognostic information does not diminish parents' desire for such information, its importance to decision making, or parents' sense of hope.

If we accept that telling the truth has the potential to destroy illusions, the most important illusion in this context is the hope that an untreatable disorder (from a professional standpoint) might still be cured – if not by the remedies of medicine, then by the effects of a miracle.

Therefore, a questionnaire study from Australia merits a closer look. It tries to define physician behaviour that is linked to the provision of hope (Hagerty et al. 2005). A major advantage of this study is that patients were able to give their personal definition of hope in addition to choosing among four pre-defined definitions that read: hope is a feeling or expectation:

- that things can go well (19%)
- that because one thing has gone wrong, it doesn't mean that other things will not go well (14%)
- that you have just as good chances (if not better) as the next person of having the best outcome (3%)
- that you can still enjoy a good quality of life, even if life expectancy is uncertain (3%).

Many participants chose different definitions that could be grouped according to: quality of life and fulfilment of goals (23%), receiving treatment that would provide the best cancer and symptom control (8%), and hope for cure and remission (8%). Answers to the question, what in general helped them to be hopeful, put the professional's role into a more modest perspective: the vast majority named family (87%), religious beliefs or spirituality (28%), or friends (24%), with scientific advances in cancer care in only 9% of cases.

Physician behaviour that was perceived as increasing hopefulness could be attributed to three factors that were labelled expert/positive/collaborative (28% of total variance explained), avoidant (14% of total variance explained), and empathic (12% of total variance explained). Typical descriptors of the first factor included such aspects as 'Appeared to know all there was to know about my cancer,' 'Said my pain will be controlled' or 'Suggested we work together on this as a team.' The factor 'avoidant' was characterised by statements like 'Used euphemisms like growth and did not use the word cancer,' and 'Appeared nervous or uncomfortable'. The factor that contributed the least was the factor that is often stressed the most in communication training for oncologists: be empathic! Typical items on this factor were 'Physician expressed his or her own feelings', 'Asked about my reaction to my prognosis', or 'Offered to answer all my questions'.

In the light of expert recommendations concerning breaking bad news and giving prognostic information, one finding needs special attention: the most powerful factor in maintaining or building up hope contains items that pertain to physician's competence as an expert in oncology. A similar finding has been reported by Parker et al. with a similar methodology (Parker et al. 2001). The most powerful factor was related to the content of what the physician was saying, explaining 33% of total variance. The second

factor could be named supportive behaviour, accounting for 11% of total variance. This factor included items like ‘Doctor telling me where I could find resources in the neighbourhood or community’ or ‘Telling me it’s okay if I am becoming upset’. The third factor was named facilitation by the authors; it contained those physician behaviours that most communication skills programs, including our own (Kiss 1999), focus upon: ‘Doctor giving full attention’ or ‘Being told in person’ or ‘Keeping eye contact’. This factor explained only 6% of total variance!

### **Suggestions for Professionals Breaking Bad News**

#### *On the Importance of Individualised Information Giving*

Few characteristics of a patient predict his or her need for information (Kutner et al. 1999). Therefore, an individualised assessment of needs and expectations is recommended. Requirements change over the course of the disease, as does the way patients and relatives cope with the burden of their suffering. A good summary can be found in a recent study (Kirk et al. 2004), in which data were generated from one-hour interviews with patients or relatives. Subjects were terminally ill cancer patients in palliative care.

Kirk et al. differentiate between two different aspects of communication: content and process characteristics. Their findings are summarised in the following section. Concerning process characteristics, patients and relatives stress the importance of healthcare providers being honest and direct. Patients, for example, would have preferred the physician to be straightforward in naming the disease as cancer. While patients want a clear message in layman terms, they also expect the healthcare professional to give information in a compassionate and empathetic manner. To the recipients of information it is clear that the process of providing information requires time, they appreciate it when the healthcare professional ‘actually sits down and really

talks to them'. When providing information, healthcare professionals must take into account patients' and relatives' ability to assimilate information. Patients and relatives felt reassured when healthcare professionals told them of their willingness to continue to provide care and not to forget about them, even when specialists become involved.

Important elements with regard to content of information delivered included healthcare providers assuming the role of an expert who is willing to provide specific prognostic information, and who can respectfully provide the level of detailed information desired by the patient or his family. Many patients seem to interpret prognostic information as a means of increasing control over the remaining period of life; they use such information as a guide to getting their affairs in order and talking with their family. Still, the provision of prognostic information should be sensitive to possible resistance, on the part of patients and their family, to processing this difficult and threatening news.

A final aspect of these interviews also related to the provision of hope. It seemed that patients and family members were able to live in parallel worlds, on the one hand, recognising the strong odds against an extended period of life, and on the other, wanting to believe in a miracle – and they often seemed to hope that their doctor might also entertain the possibility of a miracle. Furthermore, patients were well aware that any one physician is unlikely to know everything about the disease, its treatment, or all about palliative care. They also realised that the need for information varies substantially during the different phases of approaching death, as does interaction with family members. Healthcare providers should acknowledge these transitions and be sure to adapt the manner and content of the communication to the changing needs of their patients and their families.

Another additional important issue emerged: if trust was not established during the initial encounter, either when the diagnosis was first provided or the change from a

curative to a palliative approach was explained, the lack of trust remained a topic during many follow up visits. Thus, the busy surgeon or oncologist has to pay attention to the way he or she first breaks bad news. Thus the physician should be aware of his or her paramount importance for the course of the interaction between patient and healthcare professionals – that, in fact, he or she is laying the ground for all consecutive healthcare providers.

If we define hope as a confident desire that something positive is going to happen, sources of hope (circumstances or the person most likely to offer what is hoped for) and likelihood of achievement will depend on the circumstances under which someone is experiencing hope. Summarising the above quoted questionnaire and interview studies, it might seem that in the face of cancer, hope depends to a large extent on factual information, which should be given almost irrespective of its impact upon the receiver.

According to Kaplowitz (2002), patients want factual information, preferably as concrete numbers. The problem again is whether or not patients (or any sample of two persons) understand numerical information correctly, or at least in the way the information provider wants him or her to understand them. As Thorne et al. have shown (2006), this is not easy to achieve: they present findings related to various uses and abuses of numbers within cancer care communication. Giving numbers in various ways produces different and often unpredictable results with regard to understanding, interpretation, and whether or not numerical information produces hope or despair. Drawing upon the literature on risk communication, Thorn et al. propose examining the specific challenge of providing numbers in cancer communication in two interrelated areas. The first aspect relates to the provision of information about the probability of a negative event and about the time frame within which it is most likely to occur. The authors state: “Accounts of the role and meaning of numbers within patients’

communications with professional healthcare providers revealed that numerical information played a prominent role in their subjective experience and in the way they coped with the challenge of cancer.” In some instances, especially when the clinical situation was not complex, patients simply went away with the message: ‘He mentioned that the success rate with these operations was 90% which made me extremely happy’. If the news were less favourable some patients expressed their tendency to beat the odds: ‘If they tell you that you have a one percent, I’ll be in that one rather than the one that’s – you know – doomed.’

Patients were also rather creative in reframing their understanding of numerical information. This ranged from emphasising the less probable positive outcome, as above, to a frank neglect of the importance of numerical information: ‘Well, in the end, it’s just numbers.’

This second type of issue focuses on the receiver of information and highlights various sources of ambiguity or frank misunderstanding. Looking at the provider of information makes the picture even more complex: physicians have been shown to have problems in interpreting numerical data on their own. In the paper by Gigerenzer and Edwards (2003), physicians highly overestimated the probability of breast cancer in women with a positive result on mammography when they were given conditional or relative probabilities (i.e. information given in percent terms as opposed to absolute numbers). The problem in using percent terms lies in the switch between the class of individuals these figures refer to, specifically whether the class of reference is a population-based figure or whether it is an individual risk. The authors conclude: ‘The switch of reference class can confuse the minds of physicians and patients alike’ (Gigerenzer and Edwards 2003). Yet, this is the type of information patients often receive when they ask for prognostic information!

*Some Critical Remarks Concerning the Apparently Low Support for Empathy as a Central Quality of Caring*

Based upon the results from questionnaire and interview studies in cancer patients and their relatives, one is tempted to conclude that empathy has a very limited role in providing bad news. Results seem to indicate that professionals must provide more and better information if they wish to improve the quality of breaking bad news. However, one could argue that the data generated from questionnaire studies do not show a correct picture of the problem. There are two main reasons why results should be interpreted cautiously. The first is a methodological problem: when asked to list desired physician behaviour in breaking bad news, patients refer to the instance when they were first given the diagnosis of cancer or when they were informed that a switch from a curative to a palliative approach was necessary. Many patients describe this moment as if they were in an outer state of consciousness, some feeling completely numb, almost locked in and not in contact with the environment. On the other hand, others talk about an almost lucid state of consciousness. I wonder whether the task of filling in a questionnaire with pre-selected physician behaviours accurately reflects the patients' immediate experience at that very traumatic moment, or rather a retrospective reconstruction of what this interaction could have been like.

The second reason for caution is linked to the first: if patients express their desire for clear and even upsetting information, they seem to disentangle content aspects from the way the information was provided. I do not think that this is possible at all. I assume that even upsetting information – whether from an insensitive or sensitive physician – is inevitably given within an embedded context of two persons interacting. This probably holds true for any kind of information giving. Even talking about the vacation last summer takes a certain degree of sensitivity, to realise whether the recipient is still

willing or able to take in yet more information. If this task is achieved successfully, a 'sense' of STOP or CONTINUE signals emerges, which governs the quantity and type of information provided. The question of what this 'sense' might constitute will be alluded to in the last section.

#### *How Could Individualised Information Giving Be Achieved?*

Summing up the literature it becomes clear that individualised care is needed, but the question remains: how is this achieved? In an ideal conversation, healthcare provider and patient or relative interact like experienced carpenters, operating a two-handed saw: before one can even think of a different mode of action – least of all communicate about it – they instantaneously adjust speed and pressure to changes in the structure of the wood.

Much of the literature takes a different position. Instead of investigating how this type of 'understanding without (non-verbal or verbal) explication' is created, it circles around the question of which single cues or signals patients use to influence the amount of prognostic information that they wish to hear. In other words how do they convey the orders STOP or CONTINUE (providing information)? Why should this be interesting? A basic assumption underlying the research in this area is that physicians or other healthcare providers can, in fact, be trained to identify these signals, and thus adapt their information style to an individual patient's needs: The relevant research findings are employed to enable practitioners to accurately identify the transitions between phases in which the patient can cope with the situation and times when the emotional suffering becomes substantial or overwhelming. The focus is upon complex interrelated behavioural indices of facial expressions and verbal utterances that communicate the patient's state of mental competence and emotional reactivity (Morse et al. 2003).

To start from simple assumptions, one might first consider the explicit exchange of the above mentioned stop and go commands. Typical examples are the patient's explicit requests like: "Could you please tell me more about the prognosis of my cancer – with and without chemotherapy?", or simply something like: "Ok and what next?" In order to make such an open exchange of 'regulatory phrases' easier, healthcare providers have to offer space to the patient; the patient needs time to decide whether she wants more information or not. Providing space is a typical goal of patient-centred communication, which assumes that patients do not automatically and immediately fully share in the conversation but may need assistance and encouragement to do so. Typical techniques that can successfully be taught include the use of pauses, echoing, mirroring or summarising (W. A. Langewitz et al. 1998; Smith et al. 1995).

However, some patients may not be able to use the space offered by the healthcare provider. They may not be accustomed to having it, or they may be in such a state of shock that real participation in the conversation is difficult to achieve. In such moments the literature suggests that professionals would do well to pay attention to more subtle signals. Beach et al., for example (Beach et al. 2005), showed how contradictory verbal and non-verbal cues – from both patients and physicians – may serve to blur the intentions of certain utterances. When a physician asks a seemingly open question (in the sense that the patient could answer with a positive or a negative response) and, at the same time, shakes his head, he makes clear that only a negative response would meet his expectations.

A good indicator of the patient's attention is gaze: the first patient in Beach et al. gazes away from the physician several times while reconstructing her cancer experience from memory, and then looks back into his direction when she has completed her sentence.

Physicians in this study use gaze aversion to mark a shift away from the patient to 'the

facts' laid down in the chart. Hence, both partners demonstrate that they may lose contact with one another when they interrupt eye contact. Similar findings have been observed by Morse et al. (Morse et al. 2003) who investigated those verbal and non-verbal signs that indicate a shift from being able to cope with a difficult situation (one's own disease or disease and death of a close one), as opposed to attempting to maintain control of oneself in order to avert strong emotional reactions. When subjects in the interview regained control over their emotions, they re-directed gaze to the interviewer, thus demonstrating a shift from being immersed in their feelings to returning to the ongoing verbal interaction.

The metaphor of carpenters operating a two-handed saw and the meticulous analyses of researchers like Beach or Morse imply that a 'shift' during a conversation could be prompted by subtle stimuli extremely difficult to identify by an observer – all the more so by an observer who is not intimately involved in the dyadic interaction. Many researchers argue that signals of non-verbal communication enable people to regulate an intimate communication. Regulation in this sense refers, for example, to the timing of turn-taking or the length of pauses, i.e. the time they look at each other without perceiving a long gaze as transgressing or hostile (see Schmid Mast et al. 2007 for a recent overview).

However, there are instances when it is hard to imagine that even subtle non-verbal cues are governing the interaction. Alternatives to the meticulous search for subtle single observable signals or cues will be discussed in relation to Schmitz's phenomenological formulations.

### **Communication as the Formation of a Common Felt Body (Leib) – Possible Contributions of Hermann Schmitz's New Phenomenology**

Think of a person entering by chance a room where two people are talking to each other. There are instances – we all know them – when the visitor instantaneously draws back, silently closing the door without further comment. If the visitor doesn't know the interlocutors, it is very unlikely, for example, that he precisely registered the facial expressions of the two persons in the room, or interpreted them correctly based upon prior experience. It is also quite possible that he may not catch a single word or be able to rely even on the tone of voice, since the example also functions when both persons in the room are silent. Still, if there is no speech, he may, nevertheless, immediately, intuitively feel and know that this is a type of silence that is loaded with intensity and intimacy. This knowledge of the appropriate reaction – to close the door and to leave the two persons alone – comes very fast. It must rely on something other than contemplated inferences derived from the identification of particular verbal or non-verbal cues. The German philosopher and founder of New Phenomenology, Hermann Schmitz, uses the term 'multifaceted impression' to describe this phenomenon. Feelings can form part of such an impressive situation when they, for example, affect the climate inside a room by creating a particular atmosphere (Schmitz 2005a, 106–111; 2005b, 91–133). He argues that something similar occurs when a landscape is perceived as 'breath taking'; it is the felt body (*der Leib*) that reacts in those moments when we are deeply impressed. This does not refer to the height, for example, of oak-trees or the width of their crown, but to the specific, sometimes termed 'holy' atmosphere of such a place. Another good example of the phenomenon under discussion is the sense one may have that a specific action is highly appropriate for a certain situation. When we visit a person in hospital, there may come a moment when the visitor feels an urgent need to leave, sometimes immediately followed by a quick glimpse at her wristwatch. However, it is not the precise time elapsed that matters, it is the sudden realisation that the time has come to end the visit that makes the visitor turn her eyes away from the patient and glance at her

watch. In accordance with Hermann Schmitz (Schmitz 1997, 67–90), I propose that something quite similar happens when two or more people communicate with each other. Specifically when a patient and a healthcare professional jointly confront bad news, the situation is loaded with meaning, distinct from everything else that has ever happened before, as well as what might happen after this moment. The powerful existential novelty of this moment contains many elements that cannot be disentangled during the conversation. Three characteristics have been posited as the core elements of a situation in the terminology of Hermann Schmitz (Schmitz 1995, 65–79).

Situations are characterised by

- A unified entity (Gestalt) that stands out from the environment
- Meaningfulness, consisting of facts, programmes, and problems; situations ‘have something to say’
- Diffusion within the situation: not everything contained can be listed as single items; meaningfulness is dissolved in Variety.

Reading patients’ descriptions of the moment when they were given bad news or going back to our own experience in face of unexpected news, it becomes very clear that physiological processes are deeply involved. Expressions like ‘being hit in the stomach’, point to the sometimes abrupt and painful nature of these experiences; others describe a vague light-headedness and an impression of lost orientation that isolated them from the environment. In Schmitz’s terms, these are phenomena that can be attributed to the felt body (Leib) and not to the ‘corporeal body’ (Körper); they have a certain vague or metaphorical quality to them, they cannot be localized precisely. The axis along which phenomena of the felt body can be arranged is the ‘vital drive’. It is antagonistic in nature, being composed of the antagonistic forces of narrowing and widening (Engung und Weitung). Normally widening and narrowing exist together,

entwined in a mutual antagonism. Each of these characteristics can at times become dominant. When widening prevails Schmitz calls this status ‘swelling’ (like the ship that left the harbour with wind-swollen sails). When narrowing prevails, he employs the term ‘tightness’. When two or more persons meet, variations of these tendencies have the potential to exude from each individual, joining all the individuals into a kind of communal embodiment, characterized by either antagonism (as in wrestling) or solidarity (like singing in a choir or operating a two-handed saw).

I suggest that this common felt body provides the evidence – as in the example above – of the necessary and appropriate moment to leave the room; it is a ‘felt’ certainty that cannot be located anywhere within the corporeal body (Körper), and yet is clearly and unquestionably there. The healthcare professional and patient are embedded in a common situation suffused with an atmosphere. In the case of breaking bad news in oncology, this atmosphere ‘tastes of’ despair, impending death, being lost, and loneliness, while at the very same time, there may also be the hope of escaping death and being cured, a sense of clear orientation, and an underlying tone of concern, care and empathy. It may be important for healthcare professionals to accept that “any illness has objective, subjective, and relational aspects (i.e. interactions between the affected individual, the doctor, and family, as well as social context and environmental variables during the course of the disease). Together, these aspects contribute to the shared and dynamic nature of the truth of the patient’s illness (quotation from Surbone 2006)”. In this way, patients and professionals can then embark upon a delicate balancing act of exchanging different aspects of truth. Perhaps, the movement within the swinging elements of a mobile could serve as a metaphor to describe what it takes to weigh the diverse elements within this situation against each other, among them, the information needs of the patient, truthful disclosure and, without destroying hope, the physician

maintaining the position of a factual expert while at the same time clearly demonstrating care, concern and compassion. Instead of constantly checking and interpreting each other's more or less subtle cues, two individuals might focus more on impressions from the felt body. Perhaps, learning to trust these vague and intuitive sensations of appropriateness may have a unique potential for governing an interaction; they might establish the basis for the above-mentioned STOP and CONTINUE signals that form within the common situation, cues that are not necessarily merely emitted by one person and received by the other.

A recent review by Epstein comes to similar conclusions when he combines his own experience as a patient and the relevant literature on physician patient communication. He lists 'some clinical habits of physicians that promote good communication', which include attentiveness, curiosity, flexibility, and presence. Informed flexibility and the ability to see a situation with new eyes can enhance communication and diagnostic accuracy (Epstein, 2006). He and his colleague advocate heightened self-awareness to prevent errors in clinical practice, without specifically referring to the concepts of New Phenomenology (Borrell-Carrio et al. 2004). The question is, however, how heightened awareness might be achieved.

Mindfulness-based approaches represent well-defined and practical phenomenological methods that may offer physicians an avenue for enhanced awareness and sensitivity during consultations with patients. Mindfulness-based interventions derive from ancient, but well-described and systematic meditation practices aimed at cultivating the ability to sustain attention to moment-to-moment experience of both inner states and external input within an affective mindset characterized by kindness, openness, patience, tolerance, generosity and curiosity (Grossman, in press). These latter affective qualities are seen to be fundamental to the capacity to pay attention to experiences

without getting caught up in critical judgements, discursive thought or rumination about what is happening. They are also thought to be strengthened by extended mindfulness training and to generalize to feelings toward others (e.g. empathy). Thus, central elements of mindfulness-based stress reduction training (MBSR – for an overview see Grossman 2004) might provide a practical framework for the New Phenomenology within which ‘atmosphere’ and ‘situation’ can coalesce in physician-patient encounters. Assuming that occupational stress and lack of moment-to-moment awareness keep professionals from behaving in an empathic way, interventions that both promote non-judgmental awareness and reduce stress would seem promising. Indeed, recent MBSR studies in medical students have shown that just eight two-hour sessions, plus home work, reduced work-related stress and anxiety, and increased empathy scores (Rosenzweig et al. 2003; Shapiro et al. 2005).

An alternative approach also relates to the distinction between situation and constellation as outlined above. This distinction could be used during Balint groups (Balint et al. 1993). It may be argued that the setting of Balint groups provides an excellent opportunity for physicians to realise the extent to which they rely on single facts within the realm of a constellation. The Balint method consists of regular case discussion in small groups under the guidance of a qualified group leader (quotation from [www.balint.co.uk](http://www.balint.co.uk)). As soon as a case history has been presented, participants typically start asking questions like: “Is the patient married? Does he have a sibling?” They rarely reflect on their immediate multi-faceted impression that could result from mutual embodiment with the physician presenting a problem case. In layman’s terms, one might say physicians respond with their head and not with their heart. One way to avoid an immediate switch to rational reasoning is the recommendation to begin Balint group sessions with a short trance induction. The presenting physician talks about his or her patient while a trance helps the other group members ‘to listen with their hearts’ or

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in Schmitz's terms, to pay attention to the atmosphere that 'tints' the perception of their felt body.

Generally, physicians should learn to appropriately alternate between working within a situation and within a constellation, depending on the task in a given clinical encounter. For example, if the goal of the consultation is to decide whether an invasive procedure is appropriate, the constellation of individual items must be taken into account; this calls for thinking inside constellations – the arrangement of particular facts in space and time. Focussing on a task renders it difficult to focus on oneself, and vice versa – as we all know too well. Most people will have developed techniques to avoid too deep an emotional involvement or expression (“Don't start to cry at your daughter's wedding!”). Often, these techniques consist of ways to concentrate on particular sensations like squeezing the skin of the forearm, counting the number of pink roses in a flower arrangement or counting the number of words starting with an 'e'. When this approach works, the effect is not a smooth transition from one state of being into the other, but rather a sudden jump from emotional reactivity, to neutral observation. In order to improve awareness in a clinical encounter, a transition from a constellation mode into a common situation need not be complicated or take a long time. In training seminars on physician-patient communication, I propose to practice 'dipping' for just a few seconds, during which a physician might try, for just a few moments, to establish contact with the receptive organ of the atmosphere that characterises a particular situation – his or her Leib. Even such a brief interlude might be sufficient to listen with the whole body – and not just with ears and eyes – before verbally or nonverbally responding to the circumstances.

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