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The Importance of Effective Communications in End-of-Life Care and Breaking the Bad News: A Focus on Purpose and Strategies.

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Abstract

Of the various skills needed in end-of-life care, none is more important than the ability to communicate effectively. The time with terminal illness or the dying process is a time when the patients were overwhelm with several emotional feelings. This should be the time when care providers need to listen to the wishes of the dying patient's by communicating with them in the most appropriate ways. In the end-of life care, effective communication is the fundamental component to the physician and patient relationships. However, due to the lack or absence of good communications in Indian end-of-life care setting, many patients receive unwanted life-sustaining treatments along with inappropriate care which they may not prefer, if they were asked about their preference of care in the dying process. Good communication enables patients and families to make quality decision about healthcare, to prepare for the future, and to express and meet their preferences for end-of-life care. especially, when it comes for breaking the bad news to the patient and family good communication plays an important role in the face of many barriers. This present studies is mainly base on the available literatures and documents and the study is being carried out in the form of literature review, with the aim to improve the quality of life through good communication. It contain some guiding principles for physicians and other care providers on who to communicate effectively and break the bad news without hurting the emotions or feelings of the patients and families.

Key Words: *end-of-life; effective communication; depression; anxiety; bad news; breaking bad news; barriers to effective communication; terminal illness; dying individuals; decision-making; principles and objectives; communication skills.*

Introduction

"*I think the best physician is the one who has the providence to tell to the patients according to his knowledge the present situation, what has happened before, and what is going to happen in the future*."- Hippocrates.

End-of-life care is an emerging need of the dying individual's, however, the most neglected area of care in the Indian health care system as a whole. At present the needs of the dying individuals are not being met in India due to several reasons; the palliative and hospice care centers are minimal, no proper policy on end of life care strategies and its implementation, and doctors and nurses are not being trained for the particular task etc. According to World Health Organization (2012), cancer is considered as one of the top causes of death around the world with 8.2 million death in 2012. The WHO report (2014), expected that cancer will rise from 14 million to 22 million within the next two decades. According to Times of India (July, 16, 2010), it is reported that India has the worst end-of-life care, while UK have the best end-of-life care followed by Australia and New Zealand. Though palliative care was born in 1986 in India as the Shanti Avedna Sadan in Mumbai, but then, still only 1% out of 1.3 billion populations has access to palliative care, as noted by Rajagopal (2015). It has a long way to go in the area of functioning and care assessment. Cancer is known as terminal illness that cannot be cure (in most of the cases) and is likely to cause death within a limited time, is one of the leading causes of death in India. It is a time when the patients were overwhelm with several emotional feelings. This should be a time when care providers need to listen to the wishes of the dying patient's by communicating with them in the most appropriate ways. It should be noted that, In the end-of-life care, communication is the fundamental component to the physician and patient relationships. However, due to the lack or absence of good communications in Indian end-of-life care setting, many patients receive unwanted life-sustaining treatments along with inappropriate care which they may not prefer, if they were asked about their preference of care in the dying process. In the assessment of the patient's needs, good communication is also one of the important domain that need to be assess in the end of life care as it can serve as a healing instrument while dealing with emotional pain of the dying and for good decision-making. The challenges lie in the lack or absence of communication between dying patients and their health care providers. Poor communication is also the leading causes of suffering to the patients and their families.

The present study is carried out through literature review from the available existing resources, and the aim is to find a way of how to effectively implement good communication between the health care professionals and patients and their families. It is also to undermine and to understand the importance of effective communication in the process of breaking the bad news to the patient and family at the end-of-life care, and to improve the quality of life care for critically ill patients with chronic disease through effective communication. This study will focus on some of the important objectives and principles of effective communication and how to break the bad news in proper manner in the critical situation of the patient and family. It will also deal on how to understand the care preferences of the dying individuals, breaking the barriers of difficulties in communication between patients and care providers, and to make quality decisions about end-of-life care in timely manner, and to avoid inappropriate care in the dying process. Effective communication will create a platform where the dying individual can describe his/her feelings and concerns, and to make dying as natural as birth and more meaningful. The present study is created out of the available existing literatures on communication at end-of-life care and through literature reviews. This study will also help the physicians and other professionals to effectively break the bad news to patient and family in a way that they can accept and go through it. It will be helpful in guiding the multidisciplinary team working in the end-of-life care setting, to deal with distress and uncontrolled symptoms, and for ensuring good death in the face of many challenges.

Communication in End-of-Life Care

In end of life care, communication is an important component. Good communication enables the health care professionals to establish patient's priorities to inform what they wishes and sharing what they feel. In general term, communication is a continuous, two way process between two or more person in which ideas, feelings and information are shared, with the ultimate aim of reducing uncertainties and clarifying issues (APCA, 2010). Communication includes a massage that must be conveyed through a medium to a recipient. The recipient must understand the message and respond within a specific time frame. Therefore, communication always involves a process that can be broken down into a series of essential components, which includes; source, message, channel, receiver, feedback, environment, context and interference (Communications-major.com, 2018). According to Holland & Chertkov (2004), "effective communication between care providers, patients and their families is very essential in palliative care. Identification and management of symptoms, physical and psychological, hinge on interaction." Communication in an important quality of good palliative care, it is important to have a direct and compassionate communication in dealing with people with life limiting illness, in which the providers listen more than which would help the patient to tolerate and manage their own emotions, it will also strengthen the patient and clinicians/care providers relationship, which will resulted in improving the patient's and family's ability to plan and cope the illness and support them emotionally (Quill, 2014). In the end of life with terminal illness good communication is essential to good healthcare. Unhealthy communication will lead to mistrust and conflict, resulting in inappropriate and unwanted treatment. Sometime patients symptom such as pain and discomfort resulted in different sufferings which are mostly complicated, unique experiences and difficult to describe. And sometime, the physicians may have difficulty in telling the complete truth about a terminal prognosis, which will maximizes understanding (Center for Bioethics, 2005). Here, building a good communication will help in building a good repo between the physician and the patient, and appropriate and healthy treatment can take place by minimizing the misunderstanding between them. Only when fully informed about the sickness and prognosis, the patient and family can able to choose to opt for the overall treatment goal of "comfort care only" option, the physician should explicitly communicate the standard modalities of limiting life prolonging intervention such as; *Do not resuscitate* (DNR); *Withholding of life support or Nonescalation* and *Withdrawal of Life Support* (Myatra et al., 2014).

Basically, communication is of two types; Verbal and Non-Verbal communication. Basing on the style and purpose, there are two main categories of communication and they both bear their own characteristics. Communication types based on style and purpose are: *formal* and *informal* communication (notesdesk.com, 2018). Formal communication consists of certain rules and principles while communicating the message and occur in formal and official ways. On the other hand, informal communication, unlike the formal, doesn't follow authority lines and done by using channels that are in contrast with formal communication. It is only through good communication the pain and distress can be alleviated and decisions regarding treatment and advance care planning be made and provide good quality end-of-life care (Hawryluck et al., 2000).

Objectives of Effective Communication in End-of-Life Care

Communication is a process and not events that comes and goes within a time period. There are some requirements that need to be met in order to have an effective communication between the physicians, patients and families. It needs to have goal and target to make communication effective. The question is, how shall than we communicate to the terminally ill individuals and families. In answering to the above question, the joint project of Continuing Education and the Joint Centre for Bioethics between University of Toronto (2005) and The Temmy Latner Centre For Palliative Care (2000), formed an *objectives* for *Communication With Patients and Families*. The following are the objectives:

- Describe and demonstrate the components of effective communication in dealing with seriously ill patients and their families.
- Be able to break bad news, listen and respond to the needs (informational and emotional) of patients and their families at the end of life.
- In clear language appropriate to their level of understanding, honestly address the concerns of the patient and his/her family and ensure their comprehension of any imparted information.
- Know and understand the consequences of the language used to impact information,
- Be able to communicate so as to not destroy hope or provide false hope,
- Demonstrate empathy and caring using Verbal and Non-Verbal language,
- Be able to communicate and discus end-of-life decision-making in a way that is sensitive to issues of culture and religion,
- Recognize situations in which the health care provider will have difficulty in interacting with the patient and or family and develop communication skills to overcome these difficulties.

Over the past year in 2017, the annual Crude Death Rate of India was 7.33%, as per the 1000 population. Over the last three years, the crude death rate of India grew substantially from 7.3 to 7.33 (Indexmundi.com, 2018; Knoema.com, 2018). Mostly in India death occurs in hospitals, and at home through chronic illness and sudden death including accident. The need of the hours is to focus on information and effective communication skills. Poor communication at the end of life can cause deep distress, both for the patient and their loved ones, and may adversely impact on post-bereavement outcomes (Sleeman, 2013). However, in the context of Indian sub-continent, cultural differences can effect communication with the dying patients. Some cultures do not support the idea of full disclosure when it comes to illness, while others want disclosure to family members or community leaders. Over the various skills needed in palliative care, none is more important than the ability to communicate effectively (GB Shaw, 2003). The *Irish Hospice Foundation* (2013), developed Guidelines For Effective Communication Skills in their End-of-Life Care Resource Folder Version 1. The *guidelines* are as given below:

- Finding out the wishes of the patient about the involvement of family members
- Addressing situations where a patient does not wish family members to be involved
- Seeking or requesting consent from the patients or families
- Addressing situations where a patient no longer has the capacity to discuss issues/give informed consent

- How to ensure that the wishes of the patient are fully respected
- Communicating with patients and families in difficult circumstances including breaking 'bad news'
- Communicating with families of patients at end of life
- Consulting families to ascertain the patient's known wishes in respect of resuscitation and organ donation
- Face-to-face and telephone communication
- Use of appropriate language or terminology regarding sensitive issues at end of life
- Use of interpreters
- Identifying a family link/liaison person
- Cultural sensitive communication.

The African Palliative Care Association also listed down some important *principles of communication* in their Handbook of Palliative Care (2010). The following are the principles of effective communication:

- Identifies and aims to address all the needs of the patient, family and care provider (i.e. psychological, spiritual, social, cultural and physical issues);
- Provides information according to the patient's preferences (whether good or bad news);
- Invites the patient to share their agenda in a conversation;
- Aims to communicate the truth by means of accurate essential information;
- Facilitates appropriate referrals, inter-disciplinary assessment, continuity of care, discharge planning, end-of-life care and bereavement support, as well as conflict resolution and stress management;
- Advises on the resources available to address holistic needs and concerns;
- Provides patients with a sense of security, consistency and comfort;
- Educates family members and care providers on how to manage pain, distress and other symptoms in the patient and how to communicate effectively;
- Aims to improve relationships at all levels, including those involving family members, care providers and the community;
- Documents as appropriate the main discussions with the patient and family and other care providers;
- Ensure a good flow of information within and between organizations involved in service delivery;

Good communication is a fundamental component in the context of end of life care. It enables the clinicians and other care givers to establish the person's priorities and wishes, supporting them to make informed decisions (RCN, 2018). Good communication also allows patients and their families to make informed decisions about healthcare, to prepare for the future and to express and meet their preferences for end-of-life care (Sleeman, 2013). However, in delivering end of life care there would be a number of sensitive conversations with individuals approaching the end of their life and those close to them. In such context or condition, it is important to be able to initiate, facilitate and respond in these sensitive situations (Royal College of Nursing, 2018). Laura Hawryluck, in "*Ian Anderson program in End-of-Life care*" Module-5 (2000), propose some important feature for Effective Communication;

- Professional communication is a skill and like any skill can and must be learned. Being a nice person does not automatically mean you know how to communicate with patients and families.
- Communication is needed to establish the therapeutic relationship, obtain relevant information about the problems and discuss diagnosis, prognosis and treatment options according to the patient's goal to ensure quality end-of-life care.
- If physicians are not interactive and do not respond to the patient's needs for either information or emotional support, they will not be seen as caring and, their patients will not confide in them in their hopes, dreams and fears.
- Without trust, good quality of care cannot be provided since patients will not tell heath care providers about any pain or distress they are experiencing, what they are worried about in the future and what is important to them.
- At the end of life, when trust is lacking, decision-making may fail to take into consideration the dying person's goal, beliefs and values and he/she may not receive treatment he/she wants or may undergo unwanted interventions.

Probably, one of the most dreaded questions frequently asked in the end of life care is "Am I Dying?" the response need to be given depending on the circumstances and the context in which it has been said. Ongoing communication with the dying in a respectful and dignified manner should continue even when the person is unconscious as their sense of hearing may be maintained until death (RCN, 2018). Of all the various skills needed in palliative care, none is more important the ability to communicate effectively. Without such skill, little else is possible. However, there are some barriers in end of life communication which create confusion and stressful for patients and make death and dying as a failure. These barriers in end of life communication are likely to become one of the greatest challenges in the context of end of life care.

Barriers to End-of-Life Communication

A communication barrier is anything that can prevents the individuals from receiving and understanding the messages others use to convey their information, ideas and thought. The barriers can be through the use of terminology, emotional barriers and taboos, lack of attention and interest, distractions, or irrelevance to the receivers (Skillsyouneed, 2018). Aslakson and colleagues (2012), identified seven domains for high-quality end-of-life care in ICU, such as; Patient-family-centered decision making, communication, continuity of care, emotion and practical support of the patients and families, symptom management and comfort care, spiritual support, and emotional and organizational support. Communication although the key to physician-patient relationship, many barriers existed to effective communication due to emotional content of communication, these barriers are more likely to arise when the news is bad or when the patient is at the end of life (Hawryluck, 2000). There are many reasons why communication can be difficult in end of life care. Language barriers and existing issues such as deafness, confusion or condition related issues can make it harder to communicate effectively. However, because communication is such an important part of high-quality person-centred care, it is an essential area that should be considered carefully (Marie Curie, 2018). In his finding Randall Curtis (1997), say one of the barriers frequently mentioned by patients and physicians is discomfort discussing death. Several patients and physicians felt that discussing end of life care could harm or even death. Some patients feel they should wait for their doctors to raise these issues, while some doctors feel they should wait until the patient raises the issues. The barrier here is that, some patients and physicians were concerned that discussing end of life care may be harmful to the patient and may even hasten death. In most cases, barriers can be divided into those due to patients and families, due to health care providers and those due to circumstances (Hawryluck, 2000). The African Palliative Care Association in their Handbook (2010), says, the barriers in communication at end of life may create ineffective communication which might resulted into some possible consequences like; provoking greater problems, protecting patients from the reality of their situation often creates further problems, hiding the truth often leads to conspiracies of silence that usually build up to a heightened state of fear, anxiety and confusion, rather than provide one of calmness. The *Ian Anderson Program in End-of-*

Life Care Module 5 (2000), produce the "Barriers to Effective Communication" and they are as given below:

- Patients and families may misunderstand the illness and the prognosis. These misunderstanding are more common when the news is bad and, when patients and families are physically, emotionally or psychologically stressed. Physician should give information in small chunks, and check understanding. Even if patients and families seem to understand the news, physicians must be prepared to give repeated explanations and answer questions.
- Biases over the role of palliative care within society and medical profession may lead patients and families to misunderstand what palliative care involves. They may perceive involvement of palliative care as implying death is imminent and fail to understand that expertise in palliative care can help improve quality of life.
- Patients and families may lack knowledge of social, cultural norms, roles and expectations regarding death. They may never have seen or had a loved one die. This confusion over what to do may result in refusal to recognize the severity of illness and prognosis, over-emphasis on treatments leading to possible cure and failure to accept palliative treatment which is seen to mean accepting death.
- Faced with the stress of illness and threatened loss, family may struggle to realign their roles within the family community. They may lack support, may not be able to cope and may present in crisis. When in this crisis, misunderstandings, confusion and conflict within family and with the health care team are more common.
- The physical and emotional depletion that accompanies severe and or prolonged illness also decreases ability to concentrate, retain information and decreases decision-making capacity.
- Strong emotions: anger, guilt, denial over illness, threatened loss or unfulfilled dreams may consume the patient and family and result in inability or refusal to process information.
- Differences in values, beliefs or culture may make it difficult for patients and family's or expresses their emotions, needs and goals with health care providers.
- Physician may develop strong bonds with patient and family, whether they have known them for years or just a short time. These bonds may make breaking bad news or discussing issues around end-of-life care difficult to contemplate losing a patient they care for deeply.

- Physician’s personal experiences with illness and death may affect their ability to care for person who is at the end of life.
- Physical, emotional and psychological depletion may affect ability to communicate caring, empathy and compassion
- Caring for someone who is dying leads to physicians confronting their own mortality and fears of death.
- A lack of training and role models results in poor communication skills and either a lack of awareness of patient’s feelings and reactions or inability or fear of discussing these emotions.
- Physicians are not taught how to show empathy and caring and may fear emotional outbursts.
- Many physicians have been taught that displaying emotion is a sign of weakness or unprofessional. These physicians may have difficulty in discussing end-of-life issues for fear of feeling or displaying emotion.
- Physicians may fear they will be blamed for being the messenger when the nature of the news is bad and/or sad.
- If the physicians have to discuss personal, difficult end-of-life issues when they just meet a patient and family, communication is often stilted and awkward.
- As hospitals lose more and more beds, privacy becomes more and more difficult to obtain.
- There may be unavoidable interruptions if the physician is the only one on duty in, for example, the ER or ICU.

End-of-life care in ICU is often inadequate because of factors such as lack of communication between patients and health care providers, lack of patient and family-centred care and lack of emotional and psychological support. At some point it is very clear that some of these factors are due to physician-related barriers, many of which have been reported in the scientific literature (Visser et al., 2014; Nelson et al., 2010; WHO, 2018). In most cases in ICU physicians are unable to provide treatment according to patient’s wishes when the goals of care and the treatment preferences of the patient are not clear and treatment decisions are not shared with the patient and the family’s (Visser et al., 2014; Davidson et al., 2007). According to Elizabeth Knauft and colleagues (2005), in the end-of-life care, patients also endorse many barriers. The three most common barriers endorsed by patients were: 1). I would rather concentrate on staying alive than talk about death, 2). I’m not sure which doctor will be taking care of me if I get very sick, and 3). I don’t know what kind of care I would want if I get very sick. Some people consider it morbid to talk about death; it is such a taboo subject that it has only increased our fear or dying.

Good communication becomes ever more central to the holistic care of the dying. It enables physicians to establish the person's priorities and wishes, supporting them to make informed decisions. It also provides an opportunity to explore any anxieties or gaps in understanding of the situation, can reassure patients and their families, and alleviate or reduce anxiety and distress (RCN, 2018).

In the words of Stapleton and colleagues (2005), barriers and facilitators associated with communication are targets for interventions to improve end-of-life care, but such interventions will likely need to address the specific barriers relevant to individual patient-physician pairs. Mieke Visser, Luc Deliens and Dirk Houttekier (2014), outline Quality Indicators for Communication. The following are the 10 quality indicators used to evaluate communication within the team and with patients and their families:

- Meet as interdisciplinary team to discuss the patient's condition, clarify goals of treatment, and identify the patient's and family's needs and preferences.
- Address conflicts among the clinical team before meeting with the patient and/or family.
- Utilize expert clinical, ethical, and spiritual consultants when appropriate.
- Recognize the adaptations in communication strategy required for patients and families according to the chronic versus acute nature of illness, cultural and spiritual differences, and other influences.
- Meet with the patient and/or family on a regular basis to review patient's status and to answer questions.
- Communicate all information to the patient and family, including distressing news, in a clear, sensitive, unhurried manner, and in an appropriate setting.
- Clarify the patient's and family understands of the patient's condition and goals of care at the beginning and end of each meeting.
- Designate primary clinical liaison (s) who will communicate with the family daily.
- Identify the family member who will serve as the contact person for the family.
- Prepare the patient and family for the dying process.

At some point of time it is good to check the understanding of the patients and families, because it is also easy to unintentionally miscommunication and not understand others, due to common physical, psychological and socio-cultural barriers such as language, culture, stress, environment etc. so care providers must identify and address any such barriers for effective communication to happen (APCA, 2010). Establishing scientific evidence about the barriers that hinder ICU physicians in communication is important to improve the quality of end-of-life care of terminally ill ICU patients (Visser et al., 2014). It is also important to discuss with other team members about what information needs to be conveyed such as, the informational goals of the encounter, what are the perceptions of other team members regarding patient or family's understanding of situation to date, what concerns have they expressed to other team members. The differences exist in way handle information based on race, culture, religion and socio-economic class is also important (Hawryluck, 2000). In situation when the patients and families face with unexpected bad news is one of the most challenging and critical point to handle in end-of-life care. Honest conversations, sensitively navigated, will strengthen the dying patient and family. It will allow patients to priotise and prepare for the future, and reduce suffering in bereavement for those left behind. Doctors need to be equipped with the appropriate knowledge, skills and attitudes to communicate effectively with patients who are dying (Sleeman, 2013). Hippocrates (The Greek physician and also regarded as the Father of Medicine) one's said "I think the best physician is the one who has the providence to tell to the patients according to his knowledge the present situation, what has happened before, and what is going to happen in the future."

Breaking Bad News

Bad news is something that is regarded as undesirable. Buckman (1992), stated that bad news is "any news that drastically and negatively alters the patient's view of his/her future." Communicating bad news with patients and their families is a fundamental part of a health and social care professional's work. However, it is the area where many have little guidance or training (Finn and Costello, 2013). Generally, most cancer patients experience the time when a doctor must "break the bad news" to them, a time it is necessary for patients to call upon their self-determination to aid in the battle with cancer (K, Ichikura et al., 2015). Most of the patients appreciate facts about their health. However, when facing with unexpected or bad news, the patients and families are overwhelmed with; shock, grief, guilt, fear, anxiety, denial, anger, disbelief, displacement, depression, bargaining, over-dependency and shielding. In some cultures, informing the bad news is considered as harmful. The wishes in those situations should be respected and physicians should be prepared to talk to the person to person designated by the patient. It is the situation physician should explore their reasoning and allow them to express their reasoning and allowing them to express these protective emotions (Hawryluck, 2000). Buckman (2007), says bad news is "any news that drastically and negatively alters the patient's view of his or her future." Breaking bad news is an important aspect of communication, and it is one of the most challenging tasks for physician. It is essential to break the bad news in a structured fashion, with adequate advance preparation and a good follow up plan.

Breaking bad news to patients and their families is one of the most difficult responsibilities in the practice of medicine. There are many reasons why physicians have difficulty breaking bad news. A common concern is how the news will affect the patient, and it becomes the reason for withholding bad news in end-of-life care (Vandekieft, 2001). Breaking bad news even though difficult, but an important aspect of communication as it has its own goals. Rajashree (2011), outlined ***three main goals*** of breaking bad news. They are as follow:

- The process of breaking bad news need to be specifically tailored to the needs of the individual concerned, for every human being will have a different history and collection of fears and concerns.
- The goal of breaking the bad news is to do so in a way that facilitates acceptance and understanding and reduces the risk of destructive responses. The ability to break bad news well involves skills which need to be coveted, trained and kept up to date. The consequences of performing the process badly may have immediate and long term damaging effects for all involved.
- Having awareness of strategies to complete the process well is vital, but breaking bad news must never become so mechanical that patients or their families detect little individual caring and compassion.

In delivering bad news, one should remember that, the impact is influences by the difference between the patient's expectations, including his or her ambitions and plan, and the medical reality of the situation (Buckman, 1992; Irish Hospice Foundation, 2013). It is important to start off by checking what the patient already knows, and to establish a patient's information needs.

Principles of Breaking the Bad News

Breaking bad news to the patient and family is one of the hardest tasks in the medical professional realm. However, it cannot keep unspoken and need to deliver as the patient has the right to ask and enquire about his/her sickness. Physicians sometime felt that breaking the bad news might break the relationship between the physician and the patient, and sometime might resulted to sadden the dying patient with un-peaceful mindset. So, in breaking this sensitive news the physicians need to follow some guidelines or principles to create an effective communication environment. In the End-of-Life Care Resources Version-1, the *Irish Hospice Foundation* (2013), formed *Principles of Breaking Bad News to Patients*, in which the principles say's, patients have the right to:

- Accurate and true information
- Receive or not receive bad news
- Decide how information they want or do not want
- Decide who should be present during the consultation, i.e. family members including children and/or significant others
- Decide who should be informed about their diagnosis and what information that person (s) should receive.

In the process breaking the bad news, if the bad news is unexpected the news is commonly met with disbelief and when the patient or family express disbelief they are usually attempting to understand the information but can't quite accept it as true (Hawryluck, 2000). How a patient responds to bad news can be influenced by the patient's psychological context. The American Medical Association (1847) stated that, "The life if a sick person can be shorten not only by act, but also by the words or the manner of a physician." Learning general communication skills can enable physicians to break bad news in a manner that is less uncomfortable for them and more satisfying for patients and their families (Vandekieft, 2001). In the Handbook of Palliative care in Africa, The African Palliative Care Association (2010) formed *Nine Helpful Steps* to break the bad news about an illness;

- Prepare well. Know all the facts before meeting the patient or family.
- Review how must the patient already knows by asking for a summary of events. You can ask, 'can you bring me up to date on your illness and how things are now?'
- Check the patient/family wants more information and how much more. You can ask, 'we have more results now. Would you like me to give you an update on what we know? I will go step by step and you can stop me whenever you want.'
- Indicate the information to be given is serious. You can say, 'I am afraid it look rather serious,' and then allow a pause for the patient to respond.
- Encourage expression of feelings-this is the **key aspect** in terms of patient satisfaction with a session.
- Give more information if requested, systematically and in simple language.
- Listen to concerns and ask questions. You can say, 'what are your main concerns at the moment?' or 'what does this mean to you?'
- Wind down the session by summarizing issues that are raised and plan with the family the next steps.
- Make yourself available to discuss the illness further, as needed.

The location for telling the bad news is important. Must effort should be made to ensure privacy and confidentiality and to help the patient feel comfortable. The multi-disciplinary teams should begin to prepare the patient for the possibility of bad news early as possible in the diagnostic process. To tell the truth depending on how much the patient wants to know (Irish Hospice Foundation, 2013). It is a good practice for a member of staff; usually the Key Worker or a nurse, to be with the patient after bad news has been given to offer them some initial support. This would be the best time used by giving the patient an opportunity to express their thoughts and feelings by listening to the patient and being silent (East Mindland Cancer Network, 2013). In the mean time denial of bad news by the patient need to be respected and followed. Sometime when the news is unexpected, it is commonly met with disbelief, shock and followed by depression. The patient and family would try to understand the information but can't quite accept it as true. This is a time when the physician needs to show the empathy by responding these difficulties in accepting such news and help them to get through (Hawryluck, 2000). Remember, failing in communicating essential information to end-of-life care patients may result into greater problems.

Conclusion and Challenges

Being with cancer is considered as the most fearful and serious part of life one can experience in the course of illness. It is more difficult for the dying patient to go through the dying process alone either at home or in clinical settings. The dying process is the time when the individual need people support and care the most. The greatest challenge ahead in the Indian health care system is, how shall we achieve a good death with dignity and to make it happen in the end-of-life care in India. The possible solutions would be ensuring good communication with the dying patients about what matters to them the most in life and giving support to make choices of their own that would enable them to have the right care at the right time, as the that of the Scotland end-of-life care which enable the dying patients to achieve a good death with dignity in most of the cases (Marie Curie, 2018). The urgent need in the Indian end-of-life care is to focus person-centered rather than biomedic or disease-centered in treating with the dying individuals in the clinical setting. The Vandekieft (2011), ABCDE pattern of approach can also be an applicable approach in the Indian end-of-life care setting. Vandekieft, who is specialized in Palliative Care Education and Research Program, explain his pattern in the following ways; A-Advance Preparation; B-Build a Therapeutic Environment/Relationship; C-Communicate Well; D-Deal With Patient and Family Reactions; and E-Encourage and Validate Emotions. The ABCDE mnemonic of Vandekieft is a simple pattern to adopt by any care providers to face end of life and in delivering/breaking the bad news. Good communication, which is one of the important domain of specialist palliative care can be empower by allowing it as part of medical academic program in graduate and post-graduation studies in Indian medical colleges and hospitals. This will led to measurable outcomes of care and will uplift the standard of care in a higher level. It is also important to initiate and implement good communication in the Indian end of life care as a recognize and innovative model of care, and in return, will resulted into one of the best practices of care for the dying. It has to be noted that, among all the various domain of care in the end-of-life, none is more important than the ability to communicate effectively (Shaw, 2018). However, in the context of end-of-life care in India, the greatest of all the challenges lies in implementing how to communicate well with the dying patient in the modern medical education and to train the upcoming doctors and nurses to acknowledge the importance of good communication in their medical practices.

On the other hand, as Curtis & Patrick (1997) stated, discussing end-of-life is sometime seen as harmful to patients and could precipitate illness, and may even hasten death. But in the case of HIV/AIDS, patients want to discuss end-of-life care with their physicians. It is important for the care providers/physicians to be aware, and the better option would be giving the patients the opportunity to express their concerns as Curtis and Patrick noted through their several studies. In order to create an environment of effective communication with the dying patient, it is important for the physician to acknowledge their expertise and be prepared to support them through all the emotional and psychological needs (Hawryluck, 2000). Sleeman (2013) who is specialized in palliative care and its medicines proposed that, honest conversations, and sensitively navigated approach towards the dying individual's will strengthen rather than damaging the existing doctors and patients relationship. It will help the patients in a way that he/she can prioritise and prepare for what to come in future, and also will reduce suffering in bereavement for those left behind.

In the process of breaking the bad news, self care, self prepared with accurate knowledge and attitude is very important for physicians and other care providers, as bad news is always shocking, and resulted in scattering the thoughts and feeling of the patient and family. Forming group within the care staffs who can accompany the patient during and after breaking the bad news would be a better option (Irish Hospice Foundation, 2013). However, the barriers to effective in most of the Indian hospitals is that, physicians are attached with the maximum numbers of patients and to focus on a particular dying individual's is always the challenges, as the physician could not concentrated with one particular patient due to time factor. Effective communication in End-of-life care is not an event, but a process therefore, it require time to built up a relationship in clinical environment, and finding time for building up good communication is the greatest challenges for many of the physicians (Sleeman, 2013). Visser and colleagues (2014), urged the important for the physicians and other carers to examine the barriers related to and reported by patients and families in the end-of-life care. Centre for Bioethics of Minnesota (2005) also found out that, cultural barriers is also one of the important barriers for effective communication and quality of care at end-of-life as some cultures do not support the idea of full disclosure when it comes to death and dying, while others want disclosure to family members or some other responsible persons. Specially, in the secular state like India cultural barrier is always the challenges and physicians working in the end-of-life care need to be sensitive in dealing with the dying patients and families. Several existing research shows education as a barrier to effective communication in the end-of-life care. So, educating the medical practitioners on this particular task by making it as a curriculum would help in preparing the upcoming clinicians to be able to equip with proper knowledge, skills and attitudes to communicate effectively in the face of death and dying.

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