When Bad News Isn’t Necessarily Bad: Recognizing Provider Bias When Sharing Unexpected News

Carissa Carroll, MEd, Christopher Carroll, PhD, Naomi Goloff, MD, Michael B. Pitt, MD

As providers, we are often part of difficult conversations in which we have to share bad news with families. Increasingly, this skill is being recognized as a necessary competency for effective clinical practice, with curricula and protocols emerging to support training in this art of breaking bad news. In parallel, we are learning more about the role implicit bias plays within our health care encounters, in which our lived experiences provide a lens through which we approach all interactions and unconsciously shape our understanding and behavior.

In this article, we will share a family’s journey that highlights where these 2 concepts (breaking bad news and implicit bias) often intersect. Our purpose is to shine a light on an important lesson for providers: that often we bring our own biases to the table when we frame news as “bad” when ultimately, from a family’s perspective, it may not be bad at all. In doing so, we may play an integral role in sharing unexpected news, and we provide tangible skills to consider when this approach may be ideal.

JACK’S PARENTS’ STORY (CARISSA AND CHRISTOPHER CARROLL)

Soon after getting settled in our delivery room for the birth of our second son, Jack, the monitor next to my bed started beeping persistently. We were told this meant that our son’s heart rate was dropping, and the obstetrician on call that evening explained that they would have to do an emergency cesarean to deliver our infant. As they pushed me out of the delivery room to the operating room, a nurse said to my husband, Chris, that they would be back to him after the delivery. The last thing I remember is a man putting a mask over my face. I awoke to a woman saying my name. I asked if she could get my husband, and she replied, “He is with your new baby, and after you recover a little longer, you can go to be with him.”

In the meantime, a nurse and a nurse practitioner walked into the original delivery room with our infant, where Chris was waiting. The nurse practitioner handed the infant over to Chris and said, “Are you aware of trisomy 21?” He must have looked confused because she then followed up with, “Down syndrome.” She then began listing off characteristics that Jack was showing that made her suspicious of the diagnosis and said, “Well, just enjoy your baby,” and left the room.

Chris sat there alone, unsure what this meant for our infant. Would he live 6 hours, 6 days, 6 years? Approximately 45 minutes later, I was brought back to the room where Chris was waiting for my return, in which he handed me our new infant. “Here’s our new son. They think he has Down syndrome.”

After going through a variety of emotions, including shock, confusion,
The skill of communicating bad news has the need for improvement of the conversations can be challenging, eventually become imprinted for patients and families and may be shared, where we as providers play an integral role in framing how families receive this information.

Researchers of most literature focused on implicit bias point to negative stereotypes that might impact clinical decision-making and ultimately perpetuate health care disparities. What we are highlighting here, however, is that our own implicit biases or ideas about specific types of diagnoses, particularly those involving physical or intellectual disabilities, may influence how we present this news to family members or patients. Accordingly, it is important to check our own biases and take an active approach to reframing the situation to improve our communication in these situations. This is a subtle yet powerful distinction and has applications in many of the conversations we have when expectation-altering news needs to be shared.

THE ROLE OF BIAS WITHIN THE BREAKING BAD NEWS PARADIGM (DRS GOLOFF AND PITT)

Our words are powerful. Clinicians are required to communicate many types of information, often in rushed situations. How this information is delivered creates a framework for patients and families and may eventually become imprinted as their stories. Because these conversations can be challenging, the need for improvement of the skill of communicating bad news has ultimately reflect our own biases rather than an objective reality.

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**IF WE COULD REWRITE THE START TO JACK’S STORY (CARISSA AND CHRISTOPHER CARROLL)**

We’re often asked, “What would you have liked to have heard when you were given Jack’s diagnosis?” After reflecting on our experience and hearing other families’ stories, I would choose these 4 words. “I have unexpected news.” These words are validating yet not biased. And then proceed, “We have reason to believe, based on characteristics your child is showing, he may have Down syndrome, which is also called trisomy 21. We believe Jack has an extra 21st chromosome that may affect his development. I’m here to help you understand the diagnosis better and will provide you time to grieve what you may have expected, but love the baby you were given, and when the time is right, I will connect you to resources that can support you on this new, unexpected journey.”
AN APPROACH TO SHARING UNEXPECTED NEWS (ALL AUTHORS)

As we consider this subtle paradigm shift toward providers removing their own value judgments when sharing unexpected news, a few strategies emerge. First, it is essential to prepare for these conversations, realizing that our words are the beginning of this family’s story about their child’s diagnosis. Accordingly, we must begin by examining our own biases about the condition we are about to disclose. Have I only encountered children with this condition in the hospital setting? How might that affect my understanding of what life is like with the given diagnosis? If possible, we should familiarize ourselves with resources that may be available for that particular diagnosis. Team leaders should model just-in-time teaching surrounding communication strategies, including real-time simulation practice, before the conversation and, ideally, debrief with the health care team afterward. In a 2-parent household, make every effort for both parents to be present, and in the case of a diagnosis made at birth, remember to congratulate them on the birth of their new child. We recommend taking the Carrolls’ advice and use phraseology such as, “We have some news that may be unexpected,” and avoiding framing the news with, “I’m sorry.” This recommendation is grounded in studies that reveal that specific communication styles and framing influence the effectiveness of conversations, medical decision-making, and psychosocial distress experienced. Positive framing in these studies resulted in significantly less psychological distress. These results reveal that subtle differences in communication strategies contribute to meaningful differences in response to information, both short-term and long-term. Simple awareness of the impact of specific words and message formulation may improve communication effectiveness.

It is also important for providers to recognize the possible grief families will experience when encountering unexpected news and respond to their cues (verbal and otherwise). The presence of grief, however, does not mean the news is objectively or indefinitely bad, and this again reveals the importance of framing by the provider. The Carrolls describe the sentiment they and others go through as “grieving what you thought, loving what you’ve got,” and others have made the analogy to being rerouted on vacation to a different destination than planned and realizing that although it wasn’t what was expected, they are grateful for the joy this new destination afforded them. Additionally, we are not reliably good at predicting our own future happiness in the aftermath of unexpected events. One of the best ways to assist with this is to connect with people who have experienced the same news because they can provide a tangible view.

### Strategies To Implement

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<thead>
<tr>
<th>Strategies To Implement</th>
<th>Things To Avoid</th>
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<tbody>
<tr>
<td>Recognize that your words and conversation will be a part of the family’s story forever: take that role seriously, and consider how the family will retell this moment for years to come.</td>
<td>Entering a conversation unprepared</td>
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<tr>
<td>Remember to congratulate the family on the birth of their child; encourage them and others to celebrate their infant.</td>
<td>Treating the remainder of the hospitalization as a somber procession. In which the medical team indicates they are “sorry” about the news</td>
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<tr>
<td>Consider phrases such as, “I have some news to share that may be unexpected.”</td>
<td>Framing the news as “I have bad news”; this reflects your possible bias and may forever frame their child in that paradigm</td>
</tr>
<tr>
<td>Offer hope that although it may not be what they expected, their child will be able to bring their family joy and have a life filled with happy family memories.</td>
<td>Providing a perspective of what the diagnosis means their child won’t be able to do</td>
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<td>Provide expectations of what may need to happen in the short-term (additional testing, follow-up).</td>
<td>Volunteering an extensive timeline of possible outcomes and complications well beyond this hospitalization</td>
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<td>Check the pulse of the conversation and meet families where they are; recognize for some, this may be devastating news and support them in that possible grief while offering encouragement (normal to grieve what was expected).</td>
<td>Feeling that your job is solely to be a pep-talker or positive spin or to ignore the family’s concerns about the news</td>
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<tr>
<td>Offer resources, including linkages to families with children with the same diagnosis, if possible.</td>
<td>Failing to offer support beyond the hospital</td>
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**FIGURE 1**
Reframing breaking bad news as sharing unexpected news by using the example of sharing a diagnosis of Down syndrome.
into the future. Providers should strive to support families making these connections with other families with children who have the same diagnoses.

We have compiled a list of strategies for reframing conversations with the sharing of unexpected news paradigm using the diagnosis of Down syndrome as an example (Fig 1).

CONCLUSIONS (CARISSA AND CHRISTOPHER CARROLL)

Like many parents who have a child with Down syndrome, we consider ourselves “the lucky few.” Our son’s life continues to have a positive impact on those around him, and his worth has never been based on the number of chromosomes he has. We are grateful for the opportunity to use his story to help pediatric providers consider the role unintentional bias may play in the sharing of new diagnoses with families. It is our hope that we can contribute to the subtle shift toward the realization that because providers help families start a journey with an unexpected diagnosis, assigning this news the value judgment of being objectively bad is an opinion that rarely reflects the ultimate reality for these families.

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Pediatrics originally published online June 25, 2018;

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