

## The Physician as a Counselor

# **BREAKING BAD NEWS AND COMMUNICATION ALONG THE DISEASE TRAJECTORY**

Maria Fidelis C. Manalo, MD

### Case Scenario:

*An elderly female who has lived in a small farming barrio in a rural area all her life, became severely ill, and the daughter decided to bring her to Manila to find out what's wrong with her. The patient was first taken to a family physician. The diagnostic tests show that the patient has advanced stage 4 cancer and that no effective curative treatment is available. The daughter insists that the doctor not tell her mother the diagnosis because she fears the bad news would destroy her mother. Should the doctor withhold the information from the patient? Are the Filipino family's expressed wishes regarding non-disclosure an important consideration for the doctor whether to proceed with truth-telling or not?*

### Breaking Bad News

Bad news is any information that may seriously affect a person's perception and experience of the future in a negative way. It is usually associated with a terminal illness such as cancer. However, bad news can come in many forms, as for example the diagnosis of a chronic illness (e.g., chronic obstructive pulmonary disease); disability, or loss of function (e.g., glaucoma causing visual impairment); a treatment plan that is burdensome, painful, or costly (dialysis); a recently married pregnant woman's ultrasound verifies a blighted ovum; a college senior's positive Antinuclear antibody (ANA) test supports the clinical suspicion of lupus; or a manual laborer's chronic cough and weight loss proves to be pulmonary tuberculosis. It might simply be a diagnosis that comes at an inopportune time, such as unstable angina requiring angioplasty during the

holiday season or it may be a diagnosis that is incompatible with one's employment, such as a coarse tremor developing in a concert pianist.

In general necessary items to disclose include:

1. the patient's current medical status including the likely course if no treatment is provided
2. the contemplated procedure or medication
3. alternative available procedures or medication
4. anticipated risks and benefits of both
5. a statement offering an opportunity to ask further questions
6. a professional opinion about the alternatives

The physician's therapeutic privilege is one situation when telling "part of the truth" or delaying telling the whole truth is allowed. A physician may intentionally and validly not disclose or may under-disclose information, based on a sound medical judgment that to divulge the information at that precise time would be potentially harmful to the patient. Just the same, it should not be a question of whether a physician should provide adequate disclosure of necessary information to all his/her patients. Rather, the more crucial issue is how the bad news is broken to the patient first and foremost, and then to the family.

Disclosure of bad news is not something that most attending physicians are eager to do. Stories abound about how unskilled physicians blundered their way through an important conversation, sometimes resulting in serious harm to the patient. Many patients with cancer, for example, can recall in detail how their diagnosis was disclosed, even if they remember little of the conversation that followed, and they report that physician competence in these situations is critical to establishing trust.

Some physicians contend that breaking bad news is an innate skill, but this is incorrect. Physicians who are good at discussing bad news with their patients usually report that breaking bad news is a skill that they have worked hard to learn. Furthermore, studies of physician education demonstrate that communication skills can be learned, and have effects that persist long after the training is finished.

Entering difficult conversations can be challenging and stressful for all involved. Bad news can include any information that may seriously affect a person’s perception and experience of their future. How information is delivered has tremendous impact on how patients and family/caregivers hear the news, how they cope and how they make decisions. Everyone is unique in how they would like to be given information, what information they want to know and whom they want to know.

Bad news is always “in the eye of the beholder.” It is difficult to estimate the impact of the bad news until one has learned the recipient’s expectations and understanding of the situation. Speaking openly and with compassion and empathy shows patients and family/caregivers that their family physician cares for them. (INCTR Palliative Care Handbook, 2009)

**Barriers to Effective Communication of Bad News**

There are various barriers which prevent or inhibit communication of bad news (Table 1).

**Table 1. Barriers to Breaking The Bad News**

<p><b>Healthcare professional-led barriers</b></p> <ul style="list-style-type: none"> <li>• Fear of their own emotions</li> <li>• Fear of patient and family/caregiver emotions and reactions</li> <li>• Uncertainty in how to support these responses</li> <li>• Communicating information in technical language that is not easily understood</li> <li>• Avoiding discussion of distressing information</li> <li>• Giving false hope – telling patients and family/caregivers what they think they want to hear</li> </ul>
--

<p><b>Patient &amp; family caregiver-led barriers</b></p> <ul style="list-style-type: none"> <li>• Fear of what might be said</li> <li>• Not feeling prepared</li> <li>• Feeling that people are not being truthful or honest</li> <li>• Feeling that their decisions and hopes are not being respected</li> <li>• May only be able to take in information a little bit at a time</li> <li>• May have differences in what information they want each other to know</li> <li>• May have a need to seek a second opinion</li> <li>• May have limited understanding of medical/physical processes</li> <li>• May be embarrassed by own lack of knowledge</li> </ul>
--

Source: - *INCTR Palliative Care Handbook*, 2009

**Patient’s Right to the Truth**

Patients have a right to an honest and full explanation of their situation. Patients should be told as much or as little as they want to know. Patients have a right to decline information if they so wish. Without information about the disease and prognosis, patients cannot participate in their own treatment planning, cannot give informed consent to treatment, and cannot make suitable plans for themselves and their families.

Communication should be with the patient, unless the patient is not competent, they have delegated the responsibility to a family member, or religious or cultural custom requires that the male head of the family is told.

Communication about sensitive matters should be carried out in an understanding, sensitive and unhurried manner, should be given in a way that can be understood, and should be honest.

Telling patients nothing or lying to them is very likely to cause harm. There is evidence from many different countries and cultures that terminally ill patients fear the unknown more than they fear the known and will suffer less, both physically and psychologically, when given the information they want. Even in countries where traditionally patients are not told the diagnosis and are thought not to know it, many patients have a good idea of the diagnosis and its prognosis even if they have not been explicitly informed about it. Telling patients

nothing or lying to them will lead to loss of trust when the patient is informed of, or deduces the true situation. (The IAHPC Manual of Palliative Care, 2008).

Avoiding the topic can have adverse outcomes. Studies show that health professionals (HPs) who were uncomfortable with discussing prognosis and end-of-life (EOL) issues tended to avoid these conversations, resulting in patients receiving burdensome and painful treatments and not having sufficient time to prepare for death. On the other hand, by discussing this information sensitively, and encouraging the patient to share in decision-making, the HP can help the patient reset goals and choose appropriate supportive treatments rather than those that are burdensome. (Hancock et al, 2007). There is evidence that patients can discuss the topic without necessarily increasing anxiety. Seriously ill patients are not generally harmed by talking about their prognosis. Within a relatively short conversation, seriously ill patients easily accepted, and even valued, frank discussions about forgoing life support (Löfmark and Nilstun, 2000).

**Diagnostic Disclosure and Discussions About Prognosis**

When discussing further active treatment for the underlying disease with the patient, there should be truthful discussion of what therapy is or is not available and about the benefits and burdens of any therapies. The health professional should NOT say ‘there is nothing more that can be done.’ Patients interpret this to mean no treatment for anything and it is never true. Patients and families will only feel abandoned.

Patients may be told there is no further therapy for the underlying disease, but the provision of continuing care and symptom control should be stressed. If further active therapy for the underlying disease is not appropriate, emphasize the positive aspects of symptomatic and supportive palliative care.

When discussing prognoses with the patient, explain the uncertainty in estimating an individual patient’s prognosis. Avoid precise prognostication. Give a realistic time range. Provide realistic hope, helping the patients to achieve what is important for them. Recommend that family relationships and worldly affairs be attended to. Be prepared to answer questions about the process of dying. Provide on-going support and counseling. Reassure them about continuity of care. (The IAHPC Manual of Palliative Care, 2008).

**Transition to Palliation and End-of-life Care**

Discuss palliative care with the patient and their family in the context of how it can help them achieve their goals of comfort and quality of life despite the life-limiting nature of their illness. Emphasize the positive aspects of palliative care which seeks to make suffering more bearable in the final stages of illness and to ensure that the patient is supported and accompanied in his or her ordeal. (The IAHPC Manual of Palliative Care, 2008).

In situations when death is clearly imminent and inevitable (Table 2), the physician should initiate end-of-life care discussions and advance care planning.

**Table 2. Diagnosis of Dying: Signs & Symptoms of Death Approaching**

Profound tiredness and weakness	Essentially bed bound Reduced interest in getting out of bed Needing assistance with all care Less interest in things happening around them
Reduced intake of food & fluids	
Drowsy or reduced cognition	May be disoriented in time and place Difficulty concentrating Scarcely able to cooperate and converse with carers
Gaunt appearance	
Difficulty swallowing oral medication	

Source: *Guidelines for managing the last days of life in adults*. 2006. The National Council for Hospices and Specialist Palliative Care Services, London.

Advance care planning is a means for patients to record their end-of-life values and preferences, including their wishes regarding future treatments (or avoidance of them). Discussion should include the patient's wishes regarding giving or forgoing life-sustaining treatments such as resuscitation, elective intubation, surgery, dialysis, blood transfusions, blood products, diagnostic tests, artificial nutrition, hydration, antibiotics, other treatments, future hospital and/or ICU admissions. The physician should explain the possible benefits and burdens (or futility) of any intervention. (The IAHPC Manual of Palliative Care, 2008).

It is crucial for patients to understand the moral difference between euthanasia and the decision to forego so-called "aggressive medical treatment", i.e., medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. In such situations, when death is clearly imminent and inevitable, one can in conscience refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement. To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death (John Paul II, *Evangelium Vitae* 65, 1995).

Patients should be made to understand that they may request for analgesics such as strong opioids, and that it is licit for the doctors to relieve pain using such drugs, even when the result is decreased consciousness and a shortening of life, if

no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties (John Paul II, *Evangelium Vitae* 65, 1995).

Agree on an advance care plan, with provision that it can be modified if circumstances change. Offer to put into writing the advance care plan in documents such as Advance Directives or Living Will, including appointing a surrogate decision maker.

If agreement is not reached, the intervention the patient wants can be tried for a specified time, and regular assessment, review, and repeat discussions on this matter can be made, every 3 days for example, as recommended by the Liverpool Care Pathway for the Dying Patient (Marie Curie Palliative Care Institute, Liverpool, 2010).

## Strategies for Breaking Bad News

### ABCDE Mnemonic

Physicians can build on the following simple mnemonic, ABCDE, to provide hope and healing to patients receiving bad news: Advance preparation—arrange adequate time and privacy, confirm medical facts, review relevant clinical data, and emotionally prepare for the encounter. Building a therapeutic relationship—identify patient preferences regarding the disclosure of bad news. Communicating well—determine the patient's knowledge and understanding of the situation, proceed at the patient's pace, avoid medical jargon or euphemisms, allow for silence and tears, and answer questions. Dealing with patient and family reactions—assess and respond to emotional reactions and empathize with the patient. Encouraging/validating emotions—offer realistic hope based on the patient's goals and deal with your own needs. (Vandekieft, 2001)

### S-P-I-K-E-S Strategy

One protocol or method of disclosing bad news is represented by the acronym SPIKES

(Buckman, 2005), an approach that comprises the following six steps:

- S—Setting up the interview (choosing the right location, establishing rapport).
- P—Assessing the patient’s Perception of the medical situation.
- I—Obtaining the patient’s Invitation (asking the patient’s permission to explain).
- K—Giving Knowledge and information to the patient.
- E—Addressing the patient’s Emotions with empathic responses (addressing emotions that might occur during bad news disclosure and strategizing a treatment plan).

S—Strategy and Summary (summarizing the plan for the patient and family).

The SPIKES method is useful because it is short, is easily understandable, and focuses on specific skills that can be practiced. This protocol can be applied to most situations of breaking bad news, including diagnosis, recurrence, transition to palliative care, and even error disclosure (Table 5). Steps in discussing prognosis and end-of-life issues have been proposed by Von Gunten and Weissman (2005). The S-P-I-K-E-S protocol can be applied in this situation of discussing code status or the advance directives as well.

**Table 4. S-P-I-K-E-S Strategy in Breaking the Bad News and Discussing Code Status**

	DISCLOSURE (BREAKING THE BAD NEWS)	ADVANCE DIRECTIVES (DISCUSSING CODE STATUS)
<b>S (Setting)</b>	<ul style="list-style-type: none"> <li>• Privacy</li> <li>• Involve significant others</li> <li>• Sit down</li> <li>• Look attentive and calm</li> <li>• Listening mode: silence and repetition</li> <li>• Availability</li> </ul>	<ul style="list-style-type: none"> <li>• Privacy</li> <li>• Involve significant others</li> <li>• Sit down</li> <li>• Look attentive and calm</li> <li>• Listening mode: silence and repetition</li> <li>• Availability</li> <li>• Introduce the subject:</li> <li>• “I’d like to talk with you about possible health care decisions in the future.”</li> </ul>
<b>P (Perception)</b>	<p><b>Find out how much the patient knows.</b></p> <ul style="list-style-type: none"> <li>• “What did you think was going on with you when you felt the lump?”</li> <li>• “What have you been told about all this so far?”</li> <li>• “Are you worried that this might be something serious?”</li> </ul>	<p><b>Find out how much the patient knows.</b></p> <ul style="list-style-type: none"> <li>• “What do you understand about your current health situation?”</li> <li>• “What have the doctors told you about your condition?”</li> </ul>
<b>I (Invitation)</b>	<p><b>Find out how much the patient wants to know.</b></p> <ul style="list-style-type: none"> <li>• “Are you the kind of person who prefers to know all the details about what is going on?”</li> <li>• “How much information would you like me to give you about your diagnosis and treatment?”</li> <li>• “Would you like me to give you details of what is going on or would you prefer that I just tell you about treatments I am proposing?”</li> </ul>	<p><b>Find out what the patient expects</b></p> <ul style="list-style-type: none"> <li>• “What do you expect in the future?”</li> <li>• “What goals do you have for the time you have left—what is important to you?”</li> <li>• “So what you’re saying is – you want to be as comfortable as possible when the time comes?”</li> <li>• “What you’ve said is – you want us to do everything we can to fight, but when the time comes, you want to die peacefully?”</li> <li>• “Can you explain why you feel that way?”</li> </ul>

<p><b>K (Knowledge)</b></p>	<p><b>Share the information.</b></p> <p><b>Give warning statements:</b></p> <ul style="list-style-type: none"> <li>• “Unfortunately, I’ve got some bad news to tell you.”</li> <li>• “I’m so sorry to have to tell you....”</li> </ul> <p><b>Check perception:</b></p> <ul style="list-style-type: none"> <li>• “Do you see what I mean?”</li> <li>• “Is this making sense so far?”</li> </ul>	<p><b>Share the information. Discuss a CPR or DNR order.</b></p> <p><b>Give warning statements:</b></p> <ul style="list-style-type: none"> <li>• “We have agreed that the goals of care are to keep you comfortable and get you home. However, if you should suffer a cardio-respiratory arrest in spite of all of our efforts, do you want us to use heroic measures to attempt to bring you back?”</li> <li>• “How do you want things to be when you suffer a cardio-respiratory arrest?”</li> <li>• If you are asked to explain “heroic measures”, then describe the purpose, risks and benefits of CPR or DNR in greater detail.</li> </ul> <p><b>Check perception.</b></p> <ul style="list-style-type: none"> <li>• “With this in mind, I do not recommend the use of artificial or heroic means to keep you alive. If you agree with this, I will write an order in the chart that if you suffer from cardio-respiratory arrest, no attempt to resuscitate you will be made.”</li> </ul>
<p><b>E (Empathy)</b></p>	<p><b>Ask probing questions:</b></p> <ul style="list-style-type: none"> <li>• “How does that make you feel?”</li> <li>• “What do you make of what I’ve just told you?”</li> <li>• Respond to emotions. Identify the emotion and its origin.</li> <li>• “Hearing the result of the bone scan is clearly a major shock to you.”</li> <li>• “Obviously, this piece of news is very upsetting.”</li> <li>• “Clearly, this is very distressing.”</li> </ul> <p><b>Validate or normalize feelings:</b></p> <ul style="list-style-type: none"> <li>• “I can understand how you can feel that way.”</li> </ul>	<p><b>Respond to emotions. Identify the emotion and its origin.</b></p> <ul style="list-style-type: none"> <li>• The most profound initial response a physician can make may be silence, providing a reassuring touch, and offering facial tissues</li> </ul>
<p><b>S (Strategy &amp; Summary)</b></p>	<p><b>Summarize the information.</b></p> <ul style="list-style-type: none"> <li>• Give the patient an opportunity to voice any major concerns or questions.</li> <li>• Plan the next steps that need to be taken and the roles the doctor and the patient will play in taking those steps.</li> </ul>	<p><b>Summarize the information.</b></p> <ul style="list-style-type: none"> <li>• Give the patient an opportunity to voice any major concerns or questions.</li> <li>• Clarify the orders and plans that will accomplish the overall goals discussed, not just the CPR or DNR order:</li> <li>• “We will continue maximal medical therapy to meet your goals. However, if you suffer a cardio-respiratory arrest, we won’t use CPR to bring you back.”</li> <li>• “It sounds like we should move to a plan that maximizes your comfort. Therefore, in addition to a DNR order, I’d like to talk further with you how we can best do that.”</li> </ul>

Source: Manalo, MF, FEU-NRMF Journal, June 2011

## **Breaking the Bad News and Communicating About End-of-life Matters in the Philippine Context**

The holistic care provided by a family physician demands knowledge of the cultural beliefs and traditions of individual patients. When breaking the bad news and communicating about end-of-life matters to a Filipino patient, whether here or abroad, the health professional must take into account at least 3 things: (1) the appropriate verbal and nonverbal cues; (2) the complete centrality of the family for the Filipino; and (3) the necessity of integrating faith and hope into the care provided (Schmit, 2005).

### **Attention to Appropriate Verbal And Nonverbal Cues**

When revealing a diagnosis to a Filipino patient, it is important to recall the cultural implications for this illness. For example, telling the patient that he has “kanser” (the word for cancer in native Filipino language, Tagalog) is for many Filipinos tantamount to pronouncing a death sentence on them. Hence, the doctor should not be surprised nor alarmed if the patient’s response would be one of silence. The patient might not make eye contact with the physician, and might not ask questions. In such cases, the physician may opt to leave some educational materials like pamphlets about cancer with the patient, and to assure the patient that he would be available anytime if he has any questions.

Nonverbal language is extremely powerful among Filipinos. Health professionals should consider the value placed on modesty, privacy, and confidentiality (Giger and Davidhizar, 2003). Filipinos are polite people who are not confrontational, especially when it comes to questioning authority figures such as doctors and nurses. When asking a Filipino patient if he or she has any questions, health professionals should reassure the patient that any concern is worth asking, leaving ample time for a reply. Establishing a friendly rapport with Filipino patients to develop

the comfort level necessary to address concerns and ask questions is a priority. Health professionals should first address serious topics, followed by “safe” topics such as the weather, sports, and/or family (Giger and Davidhizar, 2003). It is also vital to note that many Filipinos feel uncomfortable expressing emotions in a group setting for fear of losing public face. As a result, group therapy or support groups that are normally beneficial to oncology patients may not be beneficial in helping a Filipino patient express emotions because he or she would more than likely remain silent.

Developing a level of communication among health professionals and patients is at the core of pain management. In addition to coping with their illness autonomously, many Filipino patients internalize their pain and suffer silently (Purnell and Paulanka, 2005). No matter how severe the pain, it is rare for a Filipino patient to complain. (Schmit, 2005). “Filipino patients seldom ask for pain medication for two reasons. One, they fear becoming addicted to the medications. Two, they fear that they will be a nuisance to the nurse” (G. Claveria, personal communication, October 21, 2004). Filipino patients will be reluctant to ask the nurse for pain medication for fear of creating unnecessary work for the nurse (K. Leonhardy, personal communication, January 18, 2005).

In caring for Filipino patients in pain, doctors and nurses become extremely vigilant in reading and interpreting each patient's body language (Schmit, 2005). For example, the nurses should take note that whenever a Filipino patient has his eyes closed other than when he is sleeping, it may be a physical sign of discomfort and pain (G. Claveria, personal communication, October 21, 2004).

### **The Centrality Of The Family For The Filipino**

To understand Filipinos is to accept the complete centrality of the family. The influential notion of “family” dominates and guides the life of Filipinos, including matters pertaining to health

care. Family members have a lot of say in the decision-making. Although apparently concurring or ostensibly indicating agreement, individuals, subservient to parents and elders, may actually be privately opposed to the issue or question at hand. They find it hard to reject or disagree when conversing with someone considered an authority.

In the Filipino culture, there's a tendency to shielding the sick from whatever might worsen their condition. Many family members believe that full disclosure would be detrimental to the patient's health, leading to anxiety, depression, lack of the will to fight their illness, helplessness, hopelessness, hastening their death. Many times, family members would ask the doctors to withhold breaking the bad news. They'd rather be the only ones who know and decide for the patient.

Preference for concealment appears to be the prevalent attitude in traditional cultures such as in most Asian cultures, where paternalistic-beneficent attitudes of physicians predominate over respect for the autonomy rights of patients. A crucial factor responsible for the transition from paternalism to autonomy is education. People who have little access to information have a rudimentary understanding of an illness, its treatment, diagnosis and prognosis. However, when people become educated and have access to good information, they become more aware of the scientific basis of the illness and the limits of modern medicine. And as people become more educated, they refuse to accept the authority of paternalism. They prefer to make decisions for themselves and assert their autonomy. In the case study cited, it would be difficult to fault the daughter who wants to withhold the bad news from her mother since that position is common practice in the Filipino culture. In this tradition, a family shields their loved one from the shock of a terminal diagnosis and indeed the loved one prefers not to be told. Thus the daughter has compelling cultural evidence that disclosure would cause real and predictable harm to her mother and that her mother would prefer not to be told the truth. Thus her request to the physician may be justifiable.

A family meeting should be arranged in which all the family members can discuss with the doctor whether or not to inform a patient of his or her terminal illness. The doctor should not find it uncommon that family members request him not to divulge the truth to protect the patient (Purnell and Paulanka, 2005). The family may avoid talking about advance directives or dying as some believe this may bring the event at their door. Making preparations for one's death is considered to tempt fate. As a result, many traditional Filipinos are opposed to advance directives or living wills. It would be best to approach a discussion gradually and in the presence of a trusted physician or clergy, or health care professional who is a family or extended family member (Periyakoil and Dela Cruz, 2010). If a patient's condition does start to decline, family members may request to provide most of the care for the patient whether at home or in the hospital

In intergenerational families, elders may hesitate to express preference for death at home or in hospital in consideration for the need of the family.

In the case study cited, would the physician be right to comply with the family's request? From the physician's perspective, he has no clear evidence of predictable harm, and he does not have the patient's informed consent not to be told the truth. Yet if the physician takes into consideration the Filipino tradition, he would be sympathetic to the family's request. Clearly he should take the time to have a serious discussion with the daughter and the rest of the family. He should evaluate depression risk. If the mother has a history of serious depression and the daughter strongly suspects that the bad news would put her mother in real jeopardy of suicide, he would have reason to withhold the truth from his patient. Barring suicide risk he may want to present some reasons why disclosure may help her mother. Above all, he should stress that the impact of the truth on patients depends largely on how it is told. There is no need to be blunt. Patient autonomy can be served by offering the patient the opportunity to learn the truth, at whatever level of detail the patient desires.



(St. Joseph's University - Institute of Catholic Bioethics Blogs, 2010).

Regardless of attitude, acculturation, and coping mechanism, relevant resources in which a Filipino patient may seek support and guidance include a trusted family member or a religious counselor (Giger and Davidhizar, 2003). Considering the emphasis Filipinos place on modesty, confiding in a trusted individual may also be difficult for Filipino patients despite universal fears and emotions. Considering this internalization of emotions and reluctance to ask questions, it may be beneficial to discuss the implications of the disease and treatment options with both the patient and his or her family.

### **The Necessity of Fostering Faith and Hope In Communicating with A Filipino Patient**

When revealing a diagnosis to a Filipino patient, it is important to recall the socio-cultural and religious implications for this illness. Many Filipino patients may be accepting of this illness as God's plan for them and utilize prayer. On the other hand, others may accept their planned destiny and strive to cope with this predetermined fate through medical treatment.

When seeking medical care, most Filipinos trust that part of a treatment's success is by God's will or by some mystical power (Purnell and Paulanka, 2005). Many Filipinos believe that illnesses are a result of God's ultimate plan (Davidhizar and Giger, 2004). This often has two different effects in how Filipinos cope with illness. One reaction is of acceptance. In accepting their faith-determined destiny, some Filipinos may abstain from seeking medical treatment to leave their health issues in "the hands of God" (Giger and Davidhizar, 2003).

Many Filipinos cope with their illness by praying and hoping that whatever God's will, it is best for that individual. In addition to prayer and hope as their primary coping mechanisms, it is

possible that others choose to suffer silently and avoid complaining. "No matter how bad the pain is, they may never complain. They just pray" (G. Claveria, personal communication, October 21, 2004). "Many Filipinos view pain as part of living an honorable life. In accepting pain they see it as opportunity to augment their spirituality or to atone for past sins" (Purnell and Paulanka, 2005).

Hope is another reaction, which reflects a traditional Filipino belief in combination with a Western philosophy towards illness. Despite how poor the prognosis and severity of illness, one is optimistic for a cure (Giger and Davidhizar, 2003). Healthcare is viewed as a panacea that can cure and fix all.

The ancient role of both physician and priest is quite appropriate in caring for many terminally-ill Filipino patients. The Filipino philosophy concerning death is commonly connected to their spiritual beliefs. As Catholicism teaches, death should not be feared if one has followed doctrine. Most Filipinos follow this Catholic tradition that the same Lord who has created them will also reward them with eternal life in heaven (Braun and Nichols, 1997).

For terminally-ill Filipino patients, actions such as withholding life support or increasing pain medication are considered permissible in this natural death process. On the other hand, Filipinos are not in favor of more active measures or assisted suicide. (Braun and Nichols, 1997).

Mainstreaming this respect for a dying patient includes having a Roman Catholic priest, a pastor or a spiritual counselor available, making arrangements for having the family participate in care, and having flexibility with visitation periods to ensure optimum family involvement (Purnell and Paulanka, 2005). In addition, the doctor or nurse can encourage families to bring in food that the patient likes (even if it is against hospital rules) and not wake a dying patient to draw blood or take vital signs. The above interventions can ensure that the Filipino patient is not only pain-free but also as comfortable as possible. All of these dying rituals

emphasize the significant role that both family and faith take part in the dying process of a terminally-ill Filipino patient (Schmit, 2005).

## Conclusion

As life-threatening illnesses such as "kanser" continue to afflict the Filipino society, it is pivotal for family physicians to acquire the communication skills in diagnostic disclosure and discussions about prognosis and end-of-life issues. It is essential for the family physician not only to know the strategies for breaking the bad news, but equally crucial is for him to understand the cultural values that are pertinent to most Filipinos, which include the extended family unit, faith-determined destiny and health, as well as the patient's emotional concerns whether or not they are verbalized. When caring for a Filipino patient, health professionals specifically must become accustomed and sensitive to this cultural background of the patient to be able to holistically nurture the patient physically, emotionally, and spiritually.

## References:

- INCTR Palliative Care Handbook (2009). Breaking Bad News. Available at: <http://inctr-palliative-care-handbook.wikidot.com/breaking-bad-news>. Accessed August 15, 2011.
- Doyle D, Woodruff R. (2008). Communication with Patients. The International Association for Hospice & Palliative Care (IAHPC) Manual of Palliative Care; 2nd Edition. Accessed August 15, 2011. Available at <http://www.hospicecare.com/manual/principles-main.html#COMMUNICATION>.
- Hancock K, Clayton JM, Parker SM et al. (2007) Truth-telling in discussing prognosis in advanced life-limiting illnesses: a systematic review. *Palliative Medicine* 21: 507–517
- Löfmark R, Nilstun T (2000). Not if, but how: one way to talk with patients about forgoing life support. *Postgrad Med J* ;76:26–28
- Ellershaw J. (2006). *Changing gear: guidelines for managing the last days of life in adults*. London: The National Council for Hospices and Specialist Palliative Care Services.
- John Paul II (1995). Encyclical Letter, *Evangelium Vitae: On the Value and Inviolability of Human Life*. Washington: United States Catholic Conference.
- National Cancer Institute (2011). *Communication in Cancer Care* (PDQ®). Available at: <http://www.cancer.gov/cancertopics/pdq/supportivecare/communication/healthprofessional/page5>. Accessed August 15, 2011.
- The Marie Curie Palliative Care Institute Liverpool (2010). *Liverpool Care Pathway for the Dying Patient*. Available at [http://www.mcpcil.org.uk/liverpool-care-pathway/Updated\\_LCP\\_pdfs/What\\_is\\_the\\_LCP\\_-\\_Healthcare\\_Professionals\\_-\\_April\\_2010.pdf](http://www.mcpcil.org.uk/liverpool-care-pathway/Updated_LCP_pdfs/What_is_the_LCP_-_Healthcare_Professionals_-_April_2010.pdf). Accessed August 15, 2011.
- Vandekieft G (2001). Breaking Bad News. *Am Fam Physician*, 64(12):1975-1978.
- Buckman R (2005). Breaking bad news: the S-P-I-K-E-S strategy. *Community Oncology*: 138-142
- von Gunten CF, Weissman DE (2005). Fast Fact and Concept #023: DNR Orders in the Hospital—Part 1. Available at: [http://www.eperc.mcw.edu/fastFact/ff\\_023.htm](http://www.eperc.mcw.edu/fastFact/ff_023.htm). Accessed May 17, 2011.
- Schmit K. (2005). Nursing implications for treating “Kanser” in Filipino patients. *Journal of Hospice and Palliative Nursing*. 7, 345-353.
- Giger JN, Davidhizar RE. (2003) *Transcultural Nursing: Assessment and Intervention*. 4th ed. St. Louis: Mosby.
- Purnell LD, Paulanka BJ. (2005). *Guide to Culturally Competent Health Care*. Philadelphia: F.A. Davis.
- Periyakoil, VJ, Dela Cruz. (2010). *Health and health care of Filipino American Older Adults*. In Periyakoil VS, eds. *eCampus-Geriatrics*, Stanford CA. Accessed August 15, 2011. Available at: <http://geriatrics.stanford.edu/ethnomed/filipino/>.
- Institute of Catholic Bioethics, St. Joseph’s University (2010). *SJU Blogs - Truth-telling in Medicine: Cultural Dimension*, Available at: <http://www.sju.edu/blogs/icb/?p=98>. Accessed August 15, 2011.
- Davidhizar RE, Giger JN. (2004). A review of the literature on care of clients in pain who are culturally diverse. *Int Nurs Rev*. 51:47-55
- Braun KL, Nichols R. (1997). *Death and Dying in Four Asian American Cultures: A Descriptive Study*. Honolulu: University of Hawaii.