

Blended news delivery in healthcare: a framework for injecting good news into bad news conversations

Angela M. Legg^{a*} and Kate Sweeny^b

^aDepartment of Psychology, Pace University, 861 Bedford Road, Marks Hall 25, Pleasantville, NY 10570, USA; ^bDepartment of Psychology, University of California, Riverside, CA, USA

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Clinicians often inject good news into bad news delivery, and they do so for a variety of reasons. We present a framework that draws from research in the fields of health and social psychology to shed light on situations in which clinicians add superfluous good news into bad news conversations in an effort to ease the conversation or mitigate patients' distress, a broad strategy we refer to as blended news delivery. Our framework includes predictors of clinicians' use of blended news delivery, characteristics of blended news and outcomes of this strategy for both patients and clinicians. This framework addresses a common aspect of health communication and can direct future research on ideal strategies for and likely consequences of blended news delivery and communication more broadly.

Keywords: Bad news delivery; health communication; doctor–patient communication

First the doctor told me the good news: I was going to have a disease named after me.
(Steve Martin)

Many have mined comic gold from good news/bad news scenarios in doctor–patient interactions. Perhaps because giving and getting bad health news creates anxiety for both patients and doctors alike, these jokes provide comic relief and poignant commentary about poor communication that sometimes occurs in healthcare situations. Good news, however, plays a role in health communication beyond serving as the punch line of jokes. In fact, over 80% of physicians report that they incorporate hopeful information into bad news conversations (Ptacek, Ptacek, & Ellison, 2001), and even Hippocrates believed that unpleasant discussions with patients could lead to worsening conditions (Hippocrates, 1923). We define good news as any information that the recipient perceives to be positive on balance, including optimistic interpretations of medical information, hopeful predictions about the success of treatment, reassuring comparisons and even irrelevant bits of uplifting information. We refer to the broad news-giving strategy of injecting good news into bad news conversations as *blended news delivery*.

*Corresponding author. Email: alegg@pace.edu

Blended news delivery can occur in nearly any healthcare setting. Sometimes good news is inherent to the bad news and arrives in the form of a solution or treatment plan, as in the case of a newly discovered but treatable medical condition. Other times bad news and good news come as a set. Patients getting the results from a blood panel may learn that they have normal blood sugar levels but high blood pressure, or a pregnant woman may learn that her foetus is healthy but she has gestational diabetes. However, the focus of this paper will be occasions when clinicians must deliver bad news that is neither inherently nor logistically paired with good news. That is, we focus on blended news delivery that specifically and deliberately aims to ease the process of delivering or receiving bad news. Throughout the paper, we will refer to this process as ‘injecting’ good news into bad news conversations as a vivid reminder that our focus is on the strategic and conscious introduction of superfluous positive information into an otherwise negative information stream.

Findings in unrelated literatures establish the importance of balancing out negative emotions with positive emotions (Fredrickson, 2013), balancing out negative experiences with positive ones in romantic relationships (Gottman & Silver, 1999) and balancing out negative, fear-inducing persuasive messages with positive, reassuring or high-efficacy information (e.g., Hovland, Janis, & Kelly, 1953; Janis, 1967; Peters, Ruiters, & Kok, 2013), and more relevant research suggests that balancing good and bad news is a common strategy in healthcare contexts (e.g., Ptacek et al., 2001). In this paper, we provide an organising framework that explains and predicts how clinicians deliver and patients receive blended news. This framework organises diverse literatures in social psychology, health communication and behavioural medicine and can guide future research and interventions to improve bad news delivery. Although many of the predictions of our framework apply more broadly to non-health contexts (e.g., managers giving bad news to employees, professors giving bad news to students), we focus in this paper on the context of healthcare due to the frequency and significance of bad news delivery by clinicians.

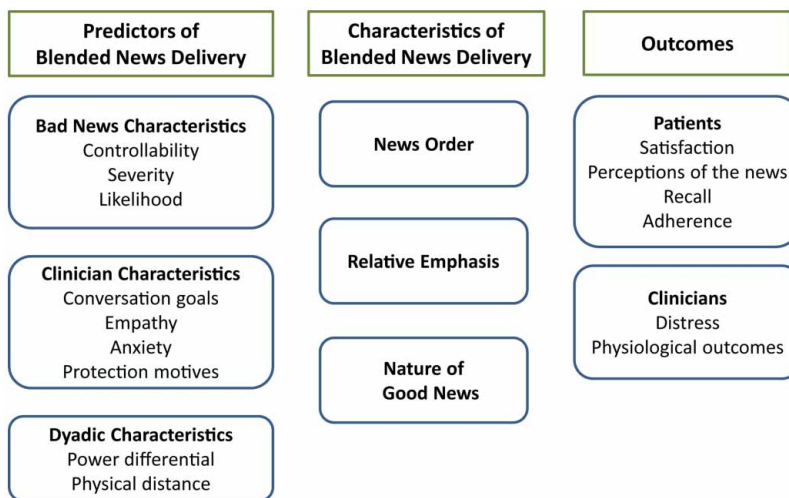


Figure 1. A framework for blended news delivery in the context of healthcare.

Our framework addresses three key considerations. We start with a discussion of the consequences of blended news delivery, establishing the benefits (and some potential costs) of this strategy for communicating bad news. We then review relevant literature informing the nature and variants of blended news delivery. Finally, we outline characteristics of the news and the clinician–patient dyad that promote the use of blended news delivery (see [Figure 1](#)). We end with suggestions for new research directions based on our framework to highlight the potential for our approach to inspire and direct research efforts in the area of bad news delivery and communication more generally.

Why use blended news delivery?

We argue that just as bad news itself can be highly consequential, so can good news (and thus blended news) delivery. In the following sections, we focus on consequences of blended news delivery for patients, including satisfaction with care, affective reactions, construal of the news, recall and adherence. However, blended news delivery can also have consequences for clinicians by reducing distress associated with bad news delivery, and thus mitigating burnout and detrimental physiological consequences (Ramirez et al., 1995; Rosenbaum, Ferguson, & Lobas, 2004; Sussman & Sproull, 1999). In fact, recent findings clearly indicate that giving bad news is a stressful task, both psychologically and physiologically (Hulsman, Smets, Karemaker, & de Haes, 2011; Hulsman et al., 2010). To the extent that injecting good news reduces the stress of bad news delivery, we anticipate that clinicians will also benefit from this approach, although we focus here on patient outcomes.

Satisfaction with care

Research in the field of health communication supports the importance of good communication between healthcare professionals and patients and its effect on patient satisfaction (DiMatteo & Hays, 1980; Haskard et al., 2008). We suggest that blended news delivery can facilitate good communication between clinicians and patients which, in turn, enhances patients' satisfaction with the news delivery process and the clinician. This relationship between good communication and patient satisfaction is likely mediated by patients' perceptions of clinicians' empathy. For example, one study found that cancer patients reported greater satisfaction when they perceived more empathy from their oncologists (Ptacek & Ptacek, 2001), and delivering bad news too abruptly or abrasively reduces patients' perceptions of physicians' empathy and decreases satisfaction with physicians and the interaction (Fredrichsen, Strang, & Carlsson, 2000). Additionally, physicians injecting some hopeful or optimistic news are perceived as more compassionate compared to physicians delivering the exact same message without a blended news approach (Tanco et al., 2015). Thus, by engaging in blended news delivery, clinicians demonstrate empathy for patients, which in turn enhances patients' satisfaction with the conversation.

However, not all blended news delivery leads to greater patient satisfaction. Indeed, overemphasising good news could cue patients to a lack of confidence on the clinicians' part if patients perceive that clinicians are delaying bad news delivery due to discomfort with the task. Therefore, we suggest that a balanced blended news delivery, one that

injects some good news or hope but does not cross the line into false hope, insincerity or unwarranted reassurance, optimises patients' satisfaction.

Affective reactions

Patients may respond to bad news with less distress and other negative emotions when clinicians use effective approaches to blended news delivery. Seemingly innocuous factors such as the order in which clinicians present good and bad news can substantially alter patients' emotional reactions, such that ending on a high note (rather than with bad news) improves emotional reactions (Legg & Sweeny, 2014), and unsurprisingly, injecting some good news into bad news delivery leaves news-recipients feeling better than including no good news at all (Nguyen, Legg, & Sweeny, 2011). Of course, patients' affective state may not be the most important consideration in all bad news conversations. As we discuss shortly, sometimes clinicians must balance their desire to mitigate patients' distress against their desire to motivate patients to take action to improve their health. However, when clinicians are concerned primarily with patients' emotional state, we propose that injecting good news into bad news delivery is an effective strategy for minimising distress.

Construal of the news

Patients may construe bad news as less severe when clinicians engage in blended news delivery. Participants in one study who received good news along with their bad news construed the news more positively than did participants who only received the bad news (Nguyen et al., 2011). We suggest that blended news delivery shifts patients' construal of bad news by 'drowning' the negativity of the bad news in a sea of positivity. For example, a clinician who rushes through the news that a patient is in dire need of surgery and then spends the rest of the visit extolling the skills of the surgical team, enumerating other cases that ended in success, and expressing optimism about the patient's outcomes will almost certainly send the patient away with little sense of the severity of the condition that necessitates the surgery. Whether this favourable construal is a benefit or cost of blended news delivery is a complex consideration, driven in part by the potential for the patient to be shattered by unpleasant surprise if the situation is worse than anticipated (e.g., Carroll, Sweeny, & Shepperd, 2006).

Recall

Patients may be more likely to recall important health information when clinicians use certain blended news delivery techniques. Recollection of information during bad news delivery is critical in healthcare settings, in which patients hear information regarding diagnoses, prognoses and treatment recommendations (Hogbin, Jenkins, & Parkin, 1992; Reynolds, Sanson-Fisher, Poole, Harker, & Byrne, 1981). Communication style and quality play a key role in patients' ability to recall and comprehend important medical information (Ong, de Haes, Hoos, & Lammes, 1995), and failure to retain this information can result in failure to adhere to recommendations and poor health outcomes (Vermeire, Hernshaw, Van Royen, & Denekens, 2001).

Blended news delivery introduces unique memory considerations due to the inclusion of multiple types of information. For example, people typically recall the

first and last pieces of information better than information that occurs in between (Ebbinghaus, 1913), which suggests that a feedback sandwich (i.e., starting and ending with good news, sandwiching the bad news in between; see next section for further discussion of this technique) could interfere with patients' memory for the bad news at the 'middle' of the sandwich. Alternatively, some scholars in the medical field argue that clinicians should deliver bad news in a straightforward manner at the beginning of the conversation between clinicians and patients to facilitate recall (Morrow, Hoagland, & Carpenter, 1983). In fact, waiting through good news for clinicians to deliver bad news can be problematic for recall (Portnoy, 2010). However, an unvarnished delivery strategy might also interfere with patients' memory for subsequent information because the shock of receiving bad news reduces their ability to focus (Brewin, 1991; Hogbin & Fallowfield, 1989). We suspect that blended news delivery risks interfering with patients' ability to recall the bad news but that this news delivery strategy may indirectly improve overall recall of positive and negative information by reducing patients' distress and thus distraction.

Adherence to recommendations

As discussed earlier, sometimes the most important goal of bad news delivery is motivating patients to change their behaviour. A meta-analysis on physician–patient communication concluded that patients who experience better communication with their physicians are more likely to adhere to their treatment recommendations (Haskard-Zolnierek & DiMatteo, 2009). Specifically, physicians who provide adequate information, demonstrate empathy, motivate their patients and guide patients to overcome barriers to behaviour change can improve patients' adherence to treatment recommendations (DiMatteo, Haskard-Zolnierek, & Martin, 2012). Appropriate use of blended news delivery may improve these aspects of communication, and thus adherence, but certain approaches to blended news may also have a direct effect on patients' motivation to adhere to recommendations. One study found that blended news techniques that end with good news undermine motivation for behaviour change, whereas ending with bad news increased the likelihood that news-recipients would pursue behaviour change, an effect mediated by fluctuations in recipients' anxiety over the course of blended news delivery (Legg & Sweeny, 2014).

The nature of blended news delivery

Save for a few papers vaguely referring to the usefulness of injecting positive or hopeful information during bad news delivery (e.g., Bor & Miller, 1993; Brewin, 1991; Marshall & Kidd, 1981), the literature has been largely silent about what blended news delivery 'looks like'. Here, we focus on three features of blended news delivery that vary across conversations and may alter the consequences of these conversations for patients and clinicians: news order, relative emphasis and the nature of the good news.

News order

By definition, all blended news delivery has an order; that is, clinicians must begin somewhere. Thus, the first feature of blended news delivery is the order of good and

bad news. Evidence suggests that people often engage in blended news delivery as a way to ease into a bad news conversation (Legg & Sweeny, 2014; Maynard, 2003) or as an exit strategy to get out of a bad news conversation (Grainger, Masterson, & Jennings, 2005; Maynard, 2003). Opening with positive information may serve an anxiety mitigation function for news-givers but could backfire in that patients perceive this news order to convey less hope (Hagerty et al., 2005). As mentioned earlier, scholars and non-scholars alike discuss best practices for giving bad news, and a commonly prescribed method by laypeople is the use of a feedback sandwich (sometimes referred to as bad news sandwiches or praise–criticism–praise patterns; Buron, & McDonald-Mann, 2007; Davies & Jacobs, 1985). This technique is characterised by presenting some good news, followed by bad news, then ending with more good news. News-givers are more likely to use a feedback sandwich when they feel particularly nervous about giving bad news or in situations in which they do not have a close relationship with the news-recipient, as is often the case in medical settings (Dohrenwood, 2002).

Relative emphasis

In addition to varying the point at which they inject good news into bad news delivery, clinicians can vary the proportion of time or attention spent on good and bad news during the conversation. When clinicians emphasise good news over bad news, they use a specific relative emphasis known as shrouding the bad and exposing the good (Maynard, 2003). Conversation analyses indicate that shrouding and exposing is a common news delivery technique that both makes the conversation easier for the clinician and follows a socially normative pattern in conversation (Brown & Levinson, 1987; Lehtinen, 2005; Maynard & Frankel, 2006). Clinicians who use this technique can either alter the relative amount of time spent delivering good and bad news, such that the bad news receives less time, or they can ‘overshadow’ bad news with good news (i.e., inject good news that is so positive as to outweigh the negativity of the bad news).

Nature of the good news

Finally, blended news delivery varies in the nature of the good news that clinicians choose to inject. One option available to clinicians is to interject an irrelevant piece of good news during bad news delivery. Although this option might be tempting for nervous clinicians, we suspect that patients benefit little from this approach to blended news delivery and may instead find it disingenuous and even irritating. We propose that clinicians have three potentially effective options available when engaging in blended news delivery: optimistic spinning, hopeful predictions and comparison-making.

Optimistic spinning

Optimistic spinning, or finding a bright side to bad news, is a technique that does not rely on the availability of substantive good news but rather on clinicians’ ability to offer an optimistic outlook on the bad news, regardless of the validity of that perspective. We define optimistic spinning as the suggestion that things might not be so bad after all, and in fact might turn out even better as a result of the bad news (without necessarily

providing a way forward). In a sense, optimistic spinning is an interpersonal version of benefit finding, which involves identifying (typically for oneself) positive outcomes related to the occurrence of a negative life event (e.g., Davis, Nolen-Hoeksema, & Larson, 1998; Helgeson, Reynolds, & Tomich, 2006). For example, a clinician may explain to a patient that the upside of undergoing a painful procedure is that they will be able to assess whether the patient can stop taking an expensive prescription medication. In some cases, optimistic spinning may appear in the form of a humorous injection such as if a clinician said to a patient facing a temporary loss of mobility, 'Well, the good news is that with this handicap tag you'll get the best parking spots for awhile.'

Hopeful projections. In addition to optimistic spinning, which puts a positive spin on a current state of affairs, clinicians can also put a positive spin on patients' future outlook by injecting hopeful projections. Hopeful projections may ease bad news delivery when effective treatment options are unclear or non-existent. For example, clinicians can imply a better future without clear basis in evidence through declarations like, 'I've seen miracles occur with patients like you,' or 'In a few years, a new drug may come on the market that could treat your condition.' Scholars and patients agree that injecting hope during bad news delivery is a beneficial strategy that conveys competence on the part of the clinician (Girgis & Sanson-Fisher, 1995; Kirk, Kirk, & Kristjanson, 2004; Parker et al., 2001) and mitigates patients' sense of despair even in dire circumstances (Leydon, 2008; Sacks, 1992).

However, clinicians also use a more treacherous form of hopeful projections when providing survival estimates (e.g., months or years left to live) to their patients. A study of cancer patients and their physicians revealed that nearly one-third of physicians readily admit that they would provide an overly optimistic survival estimate if asked for one by the patient (Lamont & Christakis, 2001). One could argue that this type of hopeful projection is ethically questionable because it violates clinicians' obligation to provide truthful information.

Comparison-making

Finally, clinicians can also offer favourable comparisons for patients, either comparing their situation to others in worse states (i.e., downward social comparison; Wills, 1981), to the patient in an earlier state (i.e., temporal comparisons, emphasising improvement; Albert, 1977), or to worse outcomes that could have but did not occur (i.e., downward counterfactual comparisons; Mandel, 2003; Roese & Olson, 1995). Such comparisons, whether to others, an earlier version of oneself, or worse 'what if' scenarios, are beneficial for buffering against distress in the face of unpleasant events (e.g., Affleck, Tennen, Urrows, Higgins, & Abeles, 2000; Aspinwall & Taylor, 1993; Mandel, 2003; Roese & Olson, 1995). For example, when delivering news of Alzheimer's disease, clinicians often engage in 'standardisation', which is a type of favourable comparison in which patients' symptoms are normalised rather than stigmatised (e.g., 'everyone suffers from cognitive deterioration, yours is a bit worse'; Karnieli-Miller, Werner, Aharon-Peretz, & Eidelman, 2007, p. 310).

Predictors of blended news delivery

Although both empirical (e.g., Ptacek et al., 2001) and anecdotal evidence points to the pervasiveness of blended news delivery, it is not universal. That is, sometimes

clinicians simply deliver bad news without attempting to ease into the conversation or soften the blow. Why would a clinician forego strategies to ease the process of bad news delivery? We suspect that clinicians faced with time shortages, heavy workloads, a lack of training in bad news delivery (Rosenbaum et al., 2004), ingrained conversation patterns and empathy deficits (Neumann et al., 2011) may be most at risk for abrupt and abrasive delivery of bad news. Our framework proposes features of the bad news and of the clinician–patient dyad that increase the likelihood that a clinician will instead choose a blended news strategy. The goal of our framework is not to provide an exhaustive list of all circumstances that could promote blended news delivery but rather to identify a central set of empirically supported predictors.

Characteristics of the news

All bad news is not created equal, and clinicians likely adjust their delivery strategy depending on characteristics of the bad news. The bad news response model (Sweeny & Shepperd, 2007) identifies three key characteristics of bad news that influence news-givers' delivery strategies: the controllability, severity and likelihood of negative consequences.

Controllability

Clinicians' news delivery strategy may be influenced by the extent to which patients can take action to change their health in response to bad health news. The bad news response model suggests that in highly controllable situations, clinicians generally should tailor news delivery towards promoting active responses (Sweeny & Shepperd, 2007). In contrast, in situations that confer little or no control, clinicians should instead deliver news in ways that promote acceptance or watchful waiting. Our framework complements the bad news response model in that we suggest that clinicians will use good news differently when delivering controllable versus uncontrollable bad news. When clinicians deliver 'terminal' bad news, they can inject good news in the form of hope or reassurance or by helping patients adopt an accepting or optimistic outlook. When clinicians deliver 'curable' bad news, they can inject good news by emphasising the controllable nature of the situation. Alternatively, clinicians may skip good news altogether when delivering controllable bad news, thus increasing the likelihood that patients will take the recommended action (Legg & Sweeny, 2014).

Severity

When health news is particularly dire, it may be difficult or even impossible for clinicians to inject good news that can compete with the intensity of bad news. Not only may it be difficult to generate good news that can compensate for severe bad news, but people also process bad information differently than good information, such that they naturally focus on the bad more than the good (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001; Sweeny & Legg, 2011). Similarly, patients who hear bad news at the beginning of a conversation with their doctor often report an inability to process any other information relayed during their interaction with the physician (Brewin, 1991; Hogbin & Fallowfield, 1989), and people often ignore good news when news-givers pair it with a bad news signifier such as 'but' (Cantillon & Sargeant, 2008).

Ironically, clinicians may be particularly motivated to smooth the conversation with good news when bad news is severe, but this strategy may offer few benefits to patients if they ignore or otherwise fail to absorb the proffered good news (Cantillon & Sargeant, 2008; Hogbin & Fallowfield, 1989). In contrast, when bad news is relatively mild, blended news delivery is likely to be more effective for reassuring or motivating patients, but it risks overpowering the bad news to the point where patients entirely fail to register it.

Likelihood

Some bad news portends numerous unpleasant outcomes, whereas other bad news is isolated and unlikely to lead to further consequences. Research examining how readily and frequently people deliver bad news demonstrates that people are more willing to give bad news with a lower likelihood of negative outcomes (i.e., something bad could happen but has not happened yet) compared to bad news of a definite nature (i.e., something bad has happened; Weenig, Groenenboom, & Wilke, 2001). Of course, clinicians rarely have a choice as to whether they give bad news to patients, even when the task is uncomfortable, and thus they may use blended news strategies to ease the experience. Clinicians delivering news with a high likelihood of negative consequences might scramble to contrive some good news to ease their conversational burden, whereas clinicians delivering low likelihood news may not need to incorporate good news because the bad news is relatively mild.

Characteristics of clinicians

Giving bad news is difficult for almost everyone, including clinicians who deliver bad news as a regular part of their profession (Ambuel & Mazzone, 2001; Buckman, 1984; Ramirez et al., 1995). We argue that clinicians vary in their likelihood of using a blended news delivery strategy based on four characteristics: conversation goals, empathy and anxiety levels, and protection motives.

Conversation goals

Clinicians enter into all bad news conversations with goals for the interaction (Sweeny, Shepperd, & Han, 2013), which typically fall into two categories: easing patients' distress and helping patients to problem-solve (MacGeorge, 2001). Our framework includes two primary conversation goals that influence how clinicians deliver bad news. First, some clinicians have the goal of inspiring patients to take action or improve their situation. To the extent that clinicians pursue the goal of changing patients' behaviour in response to bad news, we suggest that they are less likely to use a blended news delivery strategy and instead focus solely on the bad news. A second potential goal of bad news delivery is emotion protection, in which the clinician's primary focus is to buffer the patient against distress in response to the news. We suggest that clinicians who have in mind the goal of emotion protection are more likely to use blended news delivery to soften the blow of the news, and they are likely to do so in a way that emphasises any available good news (Legg & Sweeny, 2014).

Empathy

Our framework also includes clinicians' empathy towards the patient as a predictor of blended news delivery. Clinicians vary in their trait levels of empathy (Gillotti, Thompson, & McNeilis, 2002; Reynolds & Scott, 2000), and they may also feel more or less empathy towards particular patients due to the quality and nature of their relationship. For example, physicians differ in how much they like their patients based on patients' demographics, previous experience, health status and satisfaction with care (Hall, Horgan, Stein, & Roter, 2002; Levinson, Frankel, Roter, & Drum, 2006). Many existing prescriptions for bad news delivery acknowledge the importance of liking and empathy during these conversations (Buckman, 2005; Kaplan, 2010; Nardi & Keefe-Cooperman, 2006). We suggest that clinicians who experience greater empathy for patients, whether due to trait differences in empathy, patient characteristics, or the patient-clinician relationship, are more likely to engage in blended news delivery.

Anxiety

Our framework further predicts that clinicians' anxiety influences their use of blended news delivery. Research on the MUM effect (Mum about Undesirable Messages; Rosen & Tesser, 1970) demonstrates that people generally exhibit reluctance to relay negative information to others, an effect exacerbated and largely accounted for by anxiety (Merker, Hanson, & Poston, 2010). Although many news delivery guidelines focus on reducing patients' discomfort and anxiety, clinicians' own anxiety is under-emphasised. The paucity of research examining clinicians' anxiety during bad news delivery is unfortunate given that the pressures associated with relaying sometimes life-and-death news likely exceed that experienced in many other fields. In fact, clinicians report feeling anxiety before, during and after giving bad news to patients, and one-third of physicians reported above-average levels of anxiety before and during bad news delivery (Ptacek, Fries, Eberhardt, & Ptacek, 1999). Anxiety over bad news delivery can lead to a host of detrimental consequences such as clinicians engaging in distancing behaviours, not completely or clearly disclosing the bad news, or delaying the task of bad news delivery (Espinosa, Gonzalez Baron, Zamora, Ordonez, & Arranz, 1996; Vegni, Zannini, Visioli, & Moja, 2001). We suggest that clinicians who experience greater anxiety prior to and during bad news delivery will be more likely to incorporate good news to ease the delivery process, for better or worse.

Self- and other-protection motives

Clinicians vary in their motives during bad news delivery. Clinicians are often motivated to ease patients' distress and to minimise their own discomfort with bad news delivery, and they may attempt to pursue these goals simultaneously (Ptacek et al., 2001; Sweeny et al., 2013). For example, physicians delivering bad news to patients sometimes report concerns about how patients will take the news, representing an other-protective (i.e., patient-protective) motive (Vegni et al., 2001). In contrast, a clinician may also feel nervous about the threat of a patient reacting aggressively or filing a malpractice suit, which suggests a self-protective motive (Ptacek et al., 1999).

Protection motives vary from situation to situation, and they are determined in part by the degree of anxiety and empathy experienced by clinicians. Anxiety tends

to exacerbate the MUM effect, making bad news delivery more uncomfortable for clinicians (Merker et al., 2010). This distress and discomfort can then translate into self-protection motives as clinicians attempt to manage their overwhelming anxiety and discomfort over delivering bad news. In contrast, greater empathy can lead clinicians to focus on the patient and thus adopt other-protective motives. Our framework does not necessarily predict that blended news delivery is more likely when news-givers have self- or other-protective motives. Self-protective motives may prompt the use of blended news delivery in an effort to ease the news-giving process, and other-protective motives may prompt the use of blended news delivery in an effort to reduce patients' distress (Legg & Sweeny, 2014).

Dyadic characteristics

In addition to characteristics of the bad news and of clinicians, our framework also includes two characteristics of the clinician–patient dyad that are likely to influence clinicians' use of blended news delivery: power imbalances and physical distance. Regarding power, news-recipients and news-givers often do not possess the same degree of social power. Rather, news-givers frequently occupy powerful positions (clinicians) and deliver bad news to people in less powerful positions (patients). People prefer to give more positive information and less negative information to superiors or peers, and they are willing to give more negative information and less positive information to subordinates (O'Reilly & Roberts, 1974). Although this study examined a non-medical context, we suspect that the general principle applies more broadly, such that clinicians who perceive their position as one of power over the patient will feel less inclined to inject good news simply to ease bad news delivery or to soften the blow for the patient. In contrast, a clinician who feels intimidated by a patient or by the task of delivering bad news may be more likely to use a blended news strategy. Although speculative, we suspect that more experienced clinicians and clinicians who are in more stereotypically high-status positions (e.g., attending physicians, certain specialists) will be less likely to use blended news delivery.

Regarding physical distance, clinicians can deliver bad news in person, over the phone or through email or other electronic format. In fact, as technology advances, health communication increasingly takes place in electronic formats, such that patients often access diagnostic lab results and other medical information through email or online (Hassol et al., 2004; Wakefield et al., 2010). Participants in one study were more likely to delay bad news delivery when news-recipients were in sight (Bond & Anderson, 1987), and another study found that news-givers more often distorted the news in a positive direction when giving the news face-to-face or over the telephone compared to over email (Sussman & Sproull, 1999). These findings suggest that clinicians are most likely to engage in blended news delivery in person or by telephone, and less so in writing or online.

Summary and future directions for research

Many experts have thrown their hats in the metaphorical ring to provide recommendations regarding how best to deliver bad news. Despite some research on this topic (e.g., Maynard, 2003), its appearance in guidelines for bad news delivery, and frequent use during bad news conversations, the role of good news during bad news

conversations deserves more empirical attention. The framework described in this paper represents a first effort to outline the consequences, nature and predictors of blended news delivery. Our approach emphasises that good news is not simply an afterthought in bad news conversations but rather an important aspect of bad news delivery that arises often and in many forms and has consequences for both clinicians and patients.

Although our framework addresses how blended news delivery might achieve various goals and have predictable consequences, an important feature of our framework is that it does not prescribe a 'right' way to deliver health-related blended news. Instead, we recognise that bad news delivery is a complex, multi-faceted encounter in which many factors influence how news is delivered, how news is received and the subsequent outcomes for all parties involved. Thus, in contrast to the many prescriptions for bad news delivery that recommend a 'one size fits all' approach (e.g., Miranda, 2012), we recognise that each situation deserves consideration of its situational and interpersonal characteristics.

The primary goal of this framework is to initiate and guide productive programmes of research that examine the unique interplay of good and bad news. We propose four questions as targets for future research. First, how common is blended news delivery? As noted at the start of the paper, the vast majority of clinicians report injecting hopeful information into bad news conversations (Ptacek et al., 2001; see also Leydon, 2008), but targeted investigations of the frequency and nature of blended news delivery strategies are lacking.

Second, to the extent that clinicians spontaneously engage in blended news delivery, do they inject good news in a deliberate, conscious attempt to ease the conversation or mitigate patient distress, or is this strategy largely automatic and unconscious? Research on conversational goals during bad news delivery finds that clinicians see providing information as a more important goal than easing their own anxiety, mitigating patients' distress, improving patients' satisfaction, and even encouraging hope in their patients (Sweeny et al., 2013). These findings suggest that clinicians would gravitate towards an unvarnished strategy for delivering bad news, unwilling to risk obscuring the news with superfluous positive information. Thus, clinicians who engage in blended news delivery may be doing so somewhat unconsciously, swayed in the moment by their own discomfort or the patient's distress. Anecdotally, during the writing of this paper, the authors have noticed their own tendency to inject good news into bad news conversations with students, a tendency that was previously outside of their awareness.

Third, for whom and under what circumstances is blended news likely to be most effective? Our framework includes predictors of the use of blended news delivery, but the boundaries of its effectiveness remain untested. Of course, the answer to this question depends in part on the definition of 'effective'. The optimal outcome of a conversation in which a clinician delivers a terminal diagnosis is likely quite different from the optimal outcome of a conversation about the need to reduce a patient's cholesterol. In either case, however, it is possible that certain types of patients will benefit more than others from the injection of good news into the conversation. For example, defensive pessimists thrive when they expect the worst (Norem & Cantor, 1986) and thus are likely to be frustrated or even harmed by a clinician's efforts to inject hope or optimism into bad news delivery. Similarly, people who are high in both neuroticism and conscientiousness are able to harness the anxiety associated with neuroticism and use it

to motivate healthy behaviour (Turiano, Mroczek, Moynihan, & Chapman, 2013). In contrast, strategic optimists (on the other end of the spectrum from defensive pessimists) and people low in neuroticism would likely be well suited to blended news delivery.

Finally, can (and should) blended news delivery techniques be taught to clinicians? A vast research base supports the efficacy of communication training programmes and bad news delivery interventions (e.g., Baile et al., 1999; Baile, Lenzi, Parker, Buckman, & Cohen, 2002; Parathian & Taylor, 1993; Ungar, Alperin, Amiel, Beharier, & Reis, 2002), and some of these programmes recommend incorporating good news into bad news delivery. However, in the absence of clear evidence for the benefits of blended news delivery, the appropriateness of such recommendations is dubious. Furthermore, we suspect that a blanket recommendation to inject good news into bad news conversation is short-sighted, instead requiring a nuanced assessment of the nature of the patient, the relationship between the clinician and patient, the bad news and any good news that might be included. Once research sheds light on these issues, researchers and policy makers can begin to establish evidence-based recommendations for blended news delivery (see Wallace, Brown, & Hilton, 2014 for a review on intervention implementation of health psychology research). It is our intention that the framework presented in this paper will lead to advancements beyond the vague and ubiquitous suggestion to inject good news into bad news conversations and instead achieve a nuanced understanding of the nature and potential consequences of blended news delivery.

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