

plant), and the same type of extract (decoctions, mother tincture, fluid extract, or dry extract titrated in active principles).<sup>6</sup>

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**IN REPLY:** We thank Firenzuoli et al for their comments on our article.<sup>1</sup> Although the correspondents correctly indicate that there are many different possible species of the genus *Astragalus*, in our article we do state that our investigation focused on *Astragalus membranaceus* (Fisch.). The Chinese herbal pharmacopeia specifies that the root of *Astragalus* is the part to be used<sup>2</sup>; each of the articles we analyzed used the root, identified in the original Chinese language by the name Huang Qi. Firenzuoli et al also recommend that the percentage of *Astragalus* content be specified. We originally intended to include dosage amounts for each ingredient of herbal formulations used in each study, but were limited by space constraints. (We can provide this information if the correspondents contact us.)

Firenzuoli et al point out that in our article we should have identified which extraction method was used to prepare the herbal medicines given to patients. With the exception of the standardized extracts Ai Di injection and *Astragalus* single agent (for injection use) and Jin Fu Kang (for oral use), all other studies in our report used water decoctions.

Firenzuoli et al point out the variety of multiherb combinations used in these studies. In our analyses (Table 1 and Figs 2-5 of our article) we do include efficacy outcomes based on subgroups of trials in which all the studies analyzed used identical *Astragalus* formulations (Jin Fu Kang and Ai Di injection). There are important therapeutic reasons underlying the traditional Chinese practice of using multiherb formulations, which are now being understood better through recent discoveries in botanical research. For example, one of the articles included for analysis in our study<sup>3</sup> bolsters the host immune response upregulating<sup>4,5</sup> and chemotherapy toxicity-reducing<sup>6</sup> effects of *Astragalus* with additional herbs that directly attack tumor cells by inducing apoptosis (*Oldenlandia diffusa*),<sup>7</sup> inducing tumor necrosis (*Glycyrrhiza glabra*),<sup>7</sup> and inhibiting abnormal gene transcription activity (*Coix lachryma*).<sup>8</sup>

While Firenzuoli et al are correct in pointing out the importance of knowing which specific chemical constituents within *Astragalus*

may explain its therapeutic benefit, the focus of our article was on the clinical application of *Astragalus*, alone or in combination with other herbal medicines. At least one published monograph summarizes some of these constituents,<sup>9</sup> although a far richer body of knowledge is contained within the libraries and databases of China. Most are published in the original Chinese, and await analysis. We hope that our article might generate interest in work to confirm which active constituents within *Astragalus*, or combinations of active constituents from *Astragalus* and other herbs, provide clinical benefit. One such project is underway, a phase II study in the United States for non-small-cell lung cancer (NCT00260026)<sup>10</sup> using Jin Fu Kang.

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## Breaking Bad News: More Than Just Guidelines

**TO THE EDITOR:** We appreciate the consideration given by Eggly and her colleagues regarding the techniques, settings, and difficulties involved in giving bad news. In their article, Eggly et al<sup>1</sup> challenge aspects of several guidelines suggested for this purpose. It is clear, as they mention, that the main task in giving bad news is providing information to the patient and caregivers using verbal and nonverbal techniques, which enhance patient and family understanding. However, because bad news conversations can be emotionally charged, not only for the patient and family, but also for the clinician, a mindful approach<sup>2</sup> in preparing for the encounter can be quite useful for avoiding pitfalls that can occur. Specifically, it is quite common for strong patient emotion such as crying, blaming, or anger to provoke feelings of sympathy, anxiety, guilt, failure, and disappointment in the physician,<sup>3,4</sup> which can lead the physician to give false hope, provide premature reassurance or prescribe unnecessary therapies.<sup>5</sup> Our own experience in teaching this subject<sup>6,7</sup> has shown that (for both new and experienced clinicians) reflecting on one's own feelings is an essential element in overcoming these unhelpful behaviors. When the clinician becomes aware of his or her own attitudes, it is then possible to avoid communication pitfalls and support the patient. This kind of preparation for the bad news encounter would seem to be quite important.<sup>8</sup>

The central and most important principle of breaking bad news is the fact that this set of communication skills can be taught and learned.<sup>9,10</sup> Furthermore, they are not innate abilities which every clinician possesses or does not possess. This is more important than any debate about the current validity of proposed guidelines, which are basically templates for clinicians, helping them to approach the task and employ their communication skills and techniques optimally.

As Eggly et al rightly point out, these interviews rarely proceed in a linear, orderly, or planned fashion, and this makes it even more difficult to teach the techniques using only written material (which is fundamentally a linear medium). Our own experience in conducting successful workshops (including those sponsored and offered by the American Society of Clinical Oncology) strongly suggest that while guidelines can be explained, physicians benefit most by seeing examples of valuable communication strategies and demonstration of skills in realistic clinical situations, in order to understand how strategies and plans can be useful in preparing for the clinical encounter (whether the bad news had been predicted and anticipated or not). These workshops also provide participants with opportunities to practice new skills and receive personalized feedback and coaching—helping them to develop a skill set that they feel is effective.<sup>11</sup> Just as pilots gain experience in simulators, so learning and being comfortable with communication skills in advance allows their use when the need arises, and even more so when that need was anticipated or expected.

We also agree that caregivers are an essential component of patient support and similar skills are required to deal not only with

developing a therapeutic alliance with the family, but also in handling tense situations which might arise when the family objects to the patient being told the bad news or the patient does not want caregivers to know information about the illness.

Whether research evidence, such as that from videotaped encounters, will lead us to find ways to more effectively communicate with patients is still an open question. Such data undoubtedly demonstrate the uniqueness of each patient, and challenge the clinician to acquire and use techniques and skills that can be effectively employed within a template provided by proposed guidelines. In the future, it is likely that widespread teaching of and research into these skills will dramatically improve the outcome from the patient's point of view and reinforce the value of such skills to the clinician.

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**IN REPLY:** We agree with the comments of Baile et al that bad news interactions can be emotionally charged for all participants (including the clinician) and that self-reflection and other preparation by clinicians for such encounters is important in avoiding pitfalls and ensuring the most effective communication possible. However, we would extend that statement by suggesting that all interactions with patients and companions have the potential to be emotionally