PRIMARY CARE
MED437

Breaking Bad News

Objectives:

1. Define the bad news.
2. Learn about the Ethical /professional / human rights /legal issues in breaking bad news.
3. Learn Breaking bad news approaches (SPIKES, BREAKS, ABCDE's).
4. Practice How to break the bad news. e.g. Reports of cancer, hepatitis B or C, newly diagnosed diabetes, HIV positive report, etc. (role play).
5. Understand the Stages of loss and grief.

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References

- Doctor's slides and notes..
- Community Medicine OSCE file for breaking bad news cases (IMP): CLICK!

Important *Notes* *Extra* *Golden*

Editing file link

Introduction

- A difficult but fundamentally important task for **all health care professionals**. Family physicians are the main people who deliver bad news; why? *See next bullet*.
- Through building long- term, multigenerational relationships with patients and families, often find themselves -*Family physicians*- the bearer of bad or serious news.
- Physicians feel uncertain & uncomfortable while breaking bad news, leading to being distant & disengaged from their patients. Also, because they are usually the one who do the screening
- Recent studies have shown that: Patients generally (50-90%) desire full & frank disclosure, though a sizeable minority still may not want the full disclosure.
- Focused training in communication skills & techniques to facilitate breaking of bad news has been demonstrated to improve patients satisfaction & physicians comfort.

What is bad news?

- Bad news is broadly defined as information that will alter a patient's view of his or her future and result in persistent cognitive, behavioral, and emotional responses.
- Some research suggests that alternative terms, including serious news or life-altering news, may be more appropriate.
- Ultimately, the determination of what is bad news lies not with the physician, **but with the person receiving the news**. Explore ICE!!
- It alters one's self-image

> "**Any** news that adversely and seriously affects an individual's view of his or her future
>
> *-Buckman, 1984*

Cont.

- Although classically related to cancer or a terminal diagnosis, bad or serious news **may also include information related to** diagnosis of a chronic disease (e.g., diabetes mellitus), a life-altering illness (e.g., multiple sclerosis), or an injury leading to a significant change (e.g., a season-ending knee injury).
- Most of the research into the delivery of bad news, however, has focused on patients with cancer and subsequently applied to the delivery of bad or serious news in non-oncologic settings.

Examples of Conditions Requiring Breaking of Bad News

- **Cancer related diagnoses.**
- **Intrauterine foetal demise.**
- Life long illness: Diabetes, Epilepsy.
- Poor prognosis related to chronic diseases: loss of independence.
- Informing parents about their child's serious mental/physical handicap.
- Giving diagnosis of serious sexually transmitted disease …catastrophic psychosocial results.
- Non clinical situations like giving feedback to poorly performing trainees or colleagues.

Importance of learning the skill of breaking bad news

- Breaking bad news well is an essential skill for all doctors. It is something they will do hundreds if not thousands of times in their professional careers.
- Poor communication has been shown to be associated with worse clinical and psychosocial outcomes, including:

Worse pain control	Worse adherence to treatment	Confusion over prognosis
Dissatisfaction at not being involved in decision making		

- For the clinician, communication difficulties lead to:

Worse job satisfaction

Higher stress levels

Being behind a high proportion of errors and complaints.

Effective communication can help to avoid them.

Psychosocial Context

- Patients response is influenced by previous experiences & current social circumstances--- inappropriate timing
- Even simple diagnosis being incompatible with one's profession---tremors in cardiac surgeon.
- Varying needs of patient & family---patient wishes to know more himself & less information to pass on to family, family wishes vice versa.

This makes the situation much difficult to the physician. Sometimes you tell the family about the news and in other cases you don't until a specific time

Barriers to Effective Disclosure

- It is referred by some physicians like "dropping the bomb"
- Common Barriers include Physician's fears of :
    - Being blamed by patient.
    - Not knowing all the answers.
    - Inflicting pain & sufferings.
    - Own illness & death.
- Lack of training.
- Lack of time.
- Multiple physicians---who should perform the task.

SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	Evidence rating	References
Recognize that the amount of information patients want to receive about their diagnosis varies based on culture, education level, age, and sex.	B	6-8
Be aware of the stress physicians may experience before, during, and after delivering bad news. Recognize that it may affect interactions with other patients, colleagues, and family.	C	11, 12
When delivering bad news, provide a setting that assures privacy, limits interruptions, and involves family, if the patient desires.	C	20-22
When delivering bad news, use nontechnical words and avoid medical jargon. Provide empathy; avoid being blunt and allow time for patients to express emotions.	C	20-22, 27, 28
When delivering bad news, respond to patients' emotions as they arise, use empathic statements, validate responses, and ask exploratory questions when the emotion is unclear.	C	28
Use training programs such as communications courses, standardized patient scenarios, and interactive computer courses to improve skills in delivering bad news.	C	30-32

A = consistent, good-quality patient-oriented evidence; **B** = inconsistent or limited-quality patient-oriented evidence; **C** = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to https://www.aafp.org/afpsort.

Cultural barriers	Physicians fears
-Patients have unrealistic expectations of health and life, perhaps secondary to overplayed media reports of medical advances or unrealistic television portrayals. -In addition, religious diversity makes it increasingly common that the physician and patient will have different views about an afterlife. -Autonomy of patients can be altered by culture	-Evidence suggests that this stress does not lessen with a physician's years in practice or experience with delivering bad news. -Physicians fear **eliciting an emotional reaction**. The most feared -Physicians also fear that delivering truthful news about a terminal illness will leave a patient depressed, without hope, and with a shortened life span if hospice is involved. -In reality, end-of-life discussions are associated with less aggressive medical care, earlier hospice referral, and improved quality of life. -Physicians, for a variety of reasons (e.g., sensitivity to cultural norms, a patient's emotional state, respect for patient and family wishes, fear of destroying hope), often withhold information or overestimate survival.

Patient's Preferences and Perspective

Help to individualized approach to breaking bad news!!

- In the paternalistic patient-care model, the physician acts as the patient's guardian, providing selected information to steer the patient to what the physician identifies as the best decision.
- The patient-centered decision-making model became prevalent in the late 20th century, prompting the publication of several expert consensus guidelines to aid physicians in delivering bad news.
- Most patients prefer to know their diagnosis, but the amount of information they want varies among demographics. For example, younger patients, female patients, and patients with higher education levels tend to desire more detailed information.
- The amount of information is also dependent on cultural norms and ethnicity.
- Patients desire honesty, simple and clear language that they can understand, and adequate time for questions.
- Even among patients who desire details of the diagnosis and treatment options, many patients are not interested in a specific prognosis.

Patient's perspective

Most important factors for patients include:

Physician's competence, honesty & attention.

The time allowed for questions.

Straightforward & understandable diagnosis.

The use of clear language.

Family's perspective

Family members prefer:

- Privacy.
- Good attitude of the person who gives the bad news.
- Clarity of message.
- Competency of physicians.
- Time for questions.

- "It is not an isolated skill but a particular form of communication."
- Rabow & Mcphee (West J. Med 1999) described: "Clinicians focus often on relieving patients' bodily pain, less often on their emotional distress & seldom on their suffering."

Models of Breaking Bad News

There are several protocols and mnemonics to guide the delivery of bad or serious news, including: All share same points

SPIKES | ABCDE | BREAKS

Common themes of the protocols

- Establishing rapport in an appropriate setting
- Determining the patient's previous knowledge and desire for details
- Avoiding medical jargon Supporting patient emotions Allowing for questions Summarizing
- Determining next steps

FIRST MODEL: SPIKES

- **S** Setting
- **P** Perception
- **I** Invitation
- **K** Knowledge
- **E** Emotions
- **S** Strategy / Summary

SPIKES Protocol for Delivering Bad News

Step	Key points	Example phrases
Setting	Arrange for a private room or area. Have tissues available. Limit interruptions and silence electronics. Allow the patient to dress (if after examination). Maintain eye contact (defer charting). Include family or friends as patient desires.	"Before we review the results, is there anyone else you would like to be here?" "Would it be okay if I sat on the edge of your bed?"
Perception	Use open-ended questions to determine the patient's understanding. Correct misinformation and misunderstandings. Identify wishful thinking, unrealistic expectations, and denial.	"When you felt the lump in your breast, what was your first thought?" "What is your understanding of your test results thus far?"
Invitation	Determine how much information and detail a patient desires. Ask permission to give results so that the patient can control the conversation. If the patient declines, offer to meet him or her again in the future when he or she is ready (or when family is available)	"Would it be okay if I give you those test results now?" "Are you someone who likes to know all of the details, or would you prefer that I focus on the most important result?"
Knowledge	Briefly summarize events leading up to this point. Provide a warning statement to help lessen the shock and facilitate understanding, although some studies suggest that not all patients prefer to receive a warning. Use nonmedical terms and avoid jargon. Stop often to confirm understanding.	"Before I get to the results, I'd like to summarize so that we are all on the same page." "Unfortunately, the test results are worse than we initially hoped." "I know this is a lot of information; what questions do you have so far?"
Emotions	Stop and address emotions as they arise. Use empathic statements to recognize the patient's emotion. Validate responses to help the patient realize his or her feelings are important. Ask exploratory questions to help understand when the emotions are not clear.	"I can see this is not the news you were expecting." "Yes, I can understand why you felt that way." "Could you tell me more about what concerns you?"
Strategy and summary	Summarize the news to facilitate understanding. Set a plan for follow-up (referrals, further tests, treatment options). Offer a means of contact if additional questions arise. Avoid saying, "There is nothing more we can do for you." Even if the prognosis is poor, determine and support the patient's goals (e.g., symptom control, social support).	"I know this is all very frightening news, and I'm sure you will think of many more questions. When you do, write them down and we can review them when we meet again." "Even though we cannot cure your cancer, we can provide medications to control your pain and lessen your discomfort."

- **House cleaning technique** follows which consultation model? Roger Neighbour Model
- Avoid telling patients there is nothing you can do especially in the first visits, always let them feel there is something you can do other than curing them; managing their pain for example

First Model: SPIKES

good for oncologist

Steps	Key points	Example
Setting up the interview	-**How to prepare for the interview?** 1.Arrange for some privacy. 2.Involve significant others. 3.Sit down. 4.Make connection with the patient. 5.Manage time constraints and interruptions. Double check pt data and results!! -**Mental rehearsal** is a useful way for preparing for stressful tasks. This can be accomplished by reviewing the plan for telling the patient and how one will respond to patients' emotional reactions or difficult questions. As the messenger of bad news, one should expect to have negative feelings and to feel frustration or responsibility. -It is helpful to be reminded that, although bad news may be very sad for the patients, the information may be important in allowing them to plan for the future.	
Assessing the patient's **p**erception	-Before discussing the medical findings, use open-ended questions to create a reasonably accurate picture of how the patient perceives his/her medical situation. -Based on this information you can correct misinformation and tailor the bad news to what the patient understands.	-"What have you been told about your medical situation so far?" -"What is your understanding of the reasons we did the MRI?"
Obtaining the patient's **I**nvitation	When a clinician hears a patient expresses a desire for information, it may lessen the anxiety associated with delivering the bad news.	Ask the patient: "do you want to hear the test results? How would you like me to give the information about the test results? Would you like me to give you all the information or sketch out the results and spend more time discussing the treatment plan?"
Giving **k**nowledge & information to the patient	-**Warning the patient that bad news** is coming may lessen the shock that can follow the disclosure of bad news, , "Unfortunately I've got some bad news to tell you" or "I'm sorry to tell you that..." -Try to use **nonmedical words**, "spread" instead of "metastasized" and "sample of tissue" instead of "biopsy". -Avoid excessive **bluntness**, "You have very bad cancer and unless you get treatment immediately you are going to die." -Give information in small chunks and check periodically as to the patient's understanding. -When the prognosis is poor, avoid using phrases such as, "There is nothing more we can do for you."	
Addressing the patient's **E**motions with empathic responses	-Patients' emotional reactions may vary from silence to disbelief, crying, denial, or anger. -Observe for any emotion on the part of the patient. -After you have given the patient a brief period of time to express his or her feelings, let the patient know that you have connected the emotion with the reason for the emotion by making a connecting statement.	Doctor: I'm sorry to say that the x-ray shows that the chemotherapy doesn't seem to be working [pause]. Unfortunately, the tumor has grown somewhat. Patient: I've been afraid of this! [Cries] Doctor: [Moves his chair closer, offers the patient a tissue, and pauses.] I know that this isn't what you wanted to hear. I wish the news were better.
Strategy and Summary	-Before discussing a treatment plan, it is important to ask patients if they are ready at that time for such a discussion -Presenting treatment options to patients when they are available is not only a legal mandate in some cases, but it will establish the perception that the physician regards their wishes as important -Checking the patient's misunderstanding of the discussion can prevent the documented tendency of patients to overestimate the efficacy or misunderstand the purpose of the treatment	

WHAT DO WE DO IF THE PATIENT IN THIS CASE SHOWED NO EMOTIONS?

- When emotions are not clearly expressed, such as when the patient is silent, you should ask open questions to query the patient as to what they are thinking or feeling, before you make an empathic response.

You can not predict which stage the pt will be at, you must investigate to know. Also, duration of each stage varies among patients. Though depression can stay longer while bargaining stays shorter

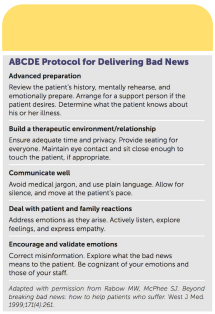
During denial stage patient won't respond to you; it is the most difficult stage to explain to the patient their diagnosis

5 Stages of Grief

1-Denial
2-Anger
3-Bargaining
4-Depression
5-Acceptance

ABCDE of delivering Bad News

- **A**dvance Preparation.
- **B**uild a therapeutic environment/relationship.
- **C**ommunicate well.
- **D**eal with patient & family reactions.
- **E**ncourage and validate emotions, Evaluate the news



ABCDE Protocol for Delivering Bad News

Advanced preparation

Review the patient's history, mentally rehearse, and emotionally prepare. Arrange for a support person if the patient desires. Determine what the patient knows about his or her illness.

Build a therapeutic environment/relationship

Ensure adequate time and privacy. Provide seating for everyone. Maintain eye contact and sit close enough to touch the patient, if appropriate.

Communicate well

Avoid medical jargon, and use plain language. Allow for silence, and move at the patient's pace.

Deal with patient and family reactions

Address emotions as they arise. Actively listen, explore feelings, and express empathy.

Encourage and validate emotions

Correct misinformation. Explore what the bad news means to the patient. Be cognizant of your emotions and those of your staff.

Adapted with permission from Rabow MW, McPhee SJ. Beyond breaking bad news: how to help patients who suffer. West J Med. 1999;171(4):261.

Step	Details
Advance preparation	• What the patient already know/understand already? • Arrange for the presence of a support person and appropriate family • Arrange a time and place to be undisturbed (Hand off beeper!) Prepare yourself emotionally • Decide on which words and phrases to use—write a script • Familiarize yourself with the relevant clinical information. Ideally, have the patient's chart on hand during the conversation. Be prepared to provide at least basic information about prognosis and treatment options.
Build a therapeutic environment / relationship	• Arrange a private, quiet place without interruptions Provide adequate seating for all • Introduce yourself to everyone present and ask for names and relationships to the patient. • Warn the patient that bad news is coming. Sit close enough to touch if appropriate • Use touch where appropriate. Some patients or family members will prefer not to be touched. Be sensitive to cultural differences and personal preference. • Reassure about pain, suffering, abandonment
Communicate well	• Be direct - "I am sorry that I have bad news for you." • Ask what the patient or family already knows and understands. • Use the words – "Cancer," "AIDS," "Death" as appropriate • Allow silence and tears, and avoid the urge to talk to overcome your own discomfort. Proceed at the patient's pace. • Allow time to answer questions; write things down and provide written information.
Deal with patient & family reactions	• Assess patient reaction: physiologic responses, cognitive coping strategies, (e.g., denial, blame, intellectualization, disbelief, acceptance), and their affective responses. • Listen actively, explore, have empathy.
Encourage and validate emotions	• Address further needs: What are the patient's immediate and near-term plans, suicidality? • Make appropriate referrals for more support Offer realistic hope • Explore what the news means to the patient • Express your own feelings

CONT

1. Use touch where appropriate.
2. Pay attention to verbal & non verbal cues.
3. Avoid inappropriate humour.
4. Assure patient that you will be available.

Communicate Well

- Speak frankly but compassionately-"I am sorry that I have bad news for you."
- Avoid medical jargon. Mostly happens to students so try to avoid it
- Allow silence & tears; proceed at patient's pace
- Have the patient describe his/her understanding of the information given.
- Encourage questions.
- Write things down & provide written information.
- Conclude each visit with a summary & follow up plan

Deal with patient and family reactions

- Assess & respond to emotional reactions.
- Be aware of cognitive coping (denial, blame, guilt, disbelief, acceptance, intellectualization).
- Allow for "shut down", when patient turns off & stops listening.
- Be empathetic; it is appropriate to say "I'm sorry or I don't know.
- Crying may be appropriate.
- Don't argue or criticize colleagues.

Encourage and validate emotions

- Offer realistic hope.
- Give adequate information to facilitate decision making.
- Explore what the news means to the patient & inquire about spiritual needs.
- Inquire about the support systems in place.
- Attend to your own needs during and following the delivery of bad news (counter-transference can be harmful).
- Use multidisciplinary services to enhance patient care (hospice).
- Formal or informal debriefing session with concerned team members may be appropriate.

BREAKS Protocol for delivering bad news

BREAKS Protocol for Delivering Bad News

Background

Know the patient's background, clinical history, and family or support person.

Rapport

Build rapport, and allow time and space to understand the patient's concerns.

Explore

Determine the patient's understanding, and start from what the patient knows about the illness.

Announce

Preface the bad news with a warning; use nonmedical language. Avoid long explanations or stories of other patients. Give no more than three pieces of information at a time.

Kindle

Address emotions as they arise. Ask the patient to recount what you said. Be aware of denial.

Summarize

Summarize the bad news and the patient's concerns. Provide a written summary for the patient. Ensure patient safety (e.g., suicidality, ability to safely drive home) and provide follow-up options (e.g., on-call physician, help line, office appointment).

NURSE Mnemonic for expressing empathy

This helps you to act on your empathy

NURSE Mnemonic for Expressing Empathy

Technique	Example phrases
Naming	"It sounds like you are worried about..." "I wonder if you are feeling angry."
Understanding	"If I understand what you are saying, you are worried how your treatments will affect your work." "This has been extremely difficult for you."
Respecting	"This must be a tremendous amount to deal with." "I am impressed with how well you have handled the treatments."
Supporting	"I will be with you during the treatments." "Please let me know what I can do to help you."
Exploring	"Tell me more about your concern about the treatment side effects." "You mentioned you are afraid about how your children will take the news. Can you tell me more about this?"

What to Do?

- Introduce yourself.
- Look to comfort and privacy.
- Determine what the patient already knows.
- Warn the patient that bad news is coming.
- Break the Bad News.
- Identify the patient's main concern.
- Summarize and check understanding.
- Offer realistic hope.
- Arrange follow up and make sure that someone is with the patient when he leaves.

How to DO it	What NOT to do
• Be sensitive. • Be empathic and consider appropriate touching. • Maintain eye contact. • Give information in small chunks. • Repeat and clarify. • Regularly check understanding. • Do not be afraid of silence or tears. • Explore patient's emotions and give him time to respond. • Be honest if you are unsure about something • Talk slowly	• Hurry • Give all the information in one go • Give too much information • Use medical jargon or unclear language/words • Lie or be economical with the truth • Be blunt. Words can be like loaded pistols/guns. • Guess the prognosis (She has got 6 months, may be 7)

Remember we don't call it difficult patient when breaking bad news goes wrong but instead difficult encounter as problems are always of patient's but physicians themselves can cause it too!

QUESTIONS

Match each step with its applicable example .

Steps	Key examples
C. Setting	"Are you someone who likes to know all of the details or would you prefer that I focus on the most important results ?" A
D. Perception	"Yes , I can understand why you felt that way " B
A. Invitation	"Before we review the results , is there anyone else you would like to be here " C
F. Knowledge	"What is your understanding of your test results thus far" D
B. Emotions	"Even though we cannot cure your cancer , we can provide medications to control your pain and lessen your discomfort" E
E. Strategy and summary	"I know this is a lot of information ; what questions do you have so far ?" F

SCENARIO

Tariq, a 55-year-old chain smoker taxi driver with persistent cough for 3 months, attends your clinic to find out the biopsy report of a lesion shown on a chest x-ray and CT scan. He is rather anxious, that he has a serious condition.

His biopsy report confirms that he has a Bronchogenic Carcinoma of right lung.

You are required to proceed with this consultation.