

Breaking Bad News

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INTRODUCTION

Breaking bad news has always been a difficult task for physicians. One way to deal with this is through formal education of doctors and medical students as good communication skills can be learned. The SPIKES protocol can be used as a template so that a physician can prepare, explore and manage the issue of breaking bad news to the patient. Done successfully, it can bring much benefit to both parties.

In the medical setting, bad news has been defined as “any news that drastically and negatively alters the patient’s view of his or her future.”¹ This can range from telling a patient he or she has a terminal illness (the most common being cancer), telling parents that their child will not develop like other children or telling someone that their loved one has died. The perception of bad news exists, to borrow an old cliché, in the “eye of the beholder.” One cannot assume its impact on a patient until comprehending his or her expectations or understanding.

Many physicians report that medical undergraduate and postgraduate programmes rarely offer formal lectures on breaking bad news. The majority of doctors rely on observing more experienced colleagues breaking bad news in a clinical setting.² Good communication is vital to improving the quality of patient management.³ It helps in eliciting and imparting information, thus facilitating the patient’s understanding and retention of information and improving compliance. In addition, good communication reduces anxiety, uncertainty, litigation and improves both patient and clinician satisfaction. Perhaps the most important concept is that good communication skills can be learned.⁴

Patients’ Perspective

Doctors must understand that, in the clinical setting, one of most important issues for patients is their lack of security. They often look for reassurance from the doctor. Patients may sense a loss of control and be overwhelmed with uncertainty, particularly if their prognosis is unclear.

When confronted with particularly bad news such as diagnosis of a terminal illness, a patient might wonder, “Now what am I going to do? I don’t know how long I am going to live.”³ Under these circumstances, patients may reflect on what is meaningful in life and seek to sort out their personal affairs. Their primary concerns often relate to life expectancy and questions regarding how much time they have left to spend with friends and family, hence their frustration when their doctor is unable to give specific details about survival and outcome.

In an article by Dias, a patient who had undergone multiple surgeries for a low-grade tumour describes how she underwent treatment at three different hospitals.³ By her own admission, the technical care she received in all three facilities was of excellent quality. However, the patient emphasised that the key difference was in the communication she had with her doctors, which varied from “truly wonderful” to “horrendous.” She describes one painful experience where, after one particular complication, the surgeon did not speak to her for the entire admission. He would go to her room everyday, but he never sat down to say, “this was what I found and this is what happened... this is what is going to happen and this is what we are going to do about it.” The patient felt that the surgeon could not deal with bad results, and his communications with her suffered as a result.

In another instance, the patient was made to feel as if her situation was hopeless, as her doctor had exhausted available treatment options and could offer her nothing other than palliative care. After much consternation, the patient reports having found a doctor with whom she shared much improved communication and who would not abandon her when treatment options narrow. In her own words, she found someone who “lifted her spirits.” The patient-doctor communication was good as she felt she was part of the team. She described these factors as being vital to her survivorship and quality of life. Although anecdotal, the authors suggest that this patient’s experiences are not uncommon and that much can be learned through gaining a better understanding of the frustrations faced by sick patients.

Doctors' Perspective

When bad news is broken insensitively, it can have a long-lasting effect on the recipient. Research has shown that once the news of a result or diagnosis is given, patients tend to miss any information that might follow, perhaps focusing instead on the immediate implications of what they have just heard.⁵ Patients who do not follow the subsequent discussion may fail to assess a physician's behaviours accurately.

Delivering bad news can be a particularly stressful task, especially for physicians in the early stages of their careers.⁶ Doctors may feel powerless to cure a patient and this can add to the difficulty. Patients can and often do get upset and the physician, as the bearer of bad news, may have to carry the brunt of any anger coming from the patient. Therefore, it is of utmost importance to separate the message from the messenger, in order to achieve clinical self-preservation.³ The key, as one senior oncologist put it, "is to recognize that we are the messenger and often times we are going to get shot."⁷

The physician also plays an unenviable role in providing two kinds of coaching: optimism and realism.⁸ Physicians adopting this role will need to check on the patient's emotional state to see that he or she understands the physician's intentions. Patients must have some sense of hope about their condition. At the same time, however, they should not have unrealistic expectations or be given the impression that their doctor will provide them with a miracle cure. In short, the physician has to foster realistic hopefulness.

SPIKES Protocol

In the year 2000, Baile and colleagues set up a six-step protocol for breaking bad news, using the acronym SPIKES.² This method was implemented by oncologists in a clinical setting and almost all were very satisfied with the resultant improvements in the programme.

Step 1: S – SETTING up Interview

Mental rehearsal is a good way of dealing with stressful tasks. Physicians should review the plan on how to break the news and anticipate how he or she might respond to a patient's emotional reactions or difficult questions.

Environment – arrange for some privacy,

preferably in a room of adequate size which can accommodate a few people. Avoid giving the news in public, for example during ward rounds. It may be a good idea to have tissues ready in case the patient starts crying.

Involve significant others – many patients wish to have someone else with them when they receive bad news. In addition, it would be a great benefit to the patient to have a nurse or social worker present during and after the bad news is delivered. This is so that after the doctor leaves, there is another member of the team with whom they can talk to about their condition.

Sit down, same eye level – this simple technique gives the impression that the doctor is not rushing and it relaxes the patient. Ideally it would be better not to have any barriers, such as a table, between doctor and patient.

Make a connection with the patient – maintaining eye contact is important. Touching the patient on the arm or holding a hand (only if patient is comfortable with it) can also help establish rapport.

Allow uninterrupted time in initial meeting – turn off pager and mobile phone. It is good practice to inform the patient of any time constraints or expected interruptions beforehand. Physicians must be on guard not to send out any non-verbal messages that he or she is in a hurry or bored, as this may cause the patient to close up and hinder future communications. For example, glancing at a watch or clock, a yawn or even suppressing one, looking away at something else happening outside the room or playing with a pen may give a negative impression.⁹

After the initial meeting, it is important to arrange for a second appointment, preferably soon, at a specific time and date.³ Advise the patient or family to write down any questions they might have. Also, leave a telephone number at which you can be contacted.

Step 2: P – Assessing the Patient's PERCEPTION

"Before you tell, ask". It is important to gauge the patient's understanding of their condition. A question such as, "what do you know about your condition so far?" gives valuable insight into what the patient thinks and allows the physician to correct misinformation and tailor subsequent

information. It will also help determine if the patient is engaging in illness denial, often characterised by wishful thinking, unrealistic expectations of treatment or omitting unfavourable medical details of his or her illness.

It would therefore be prudent to align the goals of both patient and physician.⁸ Approaching the consultation with a question such as, “could you tell me what you are hoping for? That will help me do a better job for you,” would be a good way to start exploring this issue.

Step 3: **I** – Obtaining the Patient’s **INVITATION**

Most patients wish to hear about the diagnosis and prognosis of their condition. Firstly, the clinician should not overwhelm the patient with information, but instead give it in small chunks at a time. If possible, it would be helpful for the clinician to write or draw out information that he or she is trying to convey. Some studies have shown that audio recording of the conversation is useful to the patient to make sure they understood all that was said. In addition, it allows for further questions to be clarified at a later date.¹⁰

Some patients however, do not wish to be told of their condition. Denial is a coping mechanism and clinicians should be prepared to accept that it is often an appropriate response to bad news. If the patient does not want to be informed of any details, the physician should offer his or her availability to answer any future questions should they arise.

Step 4: **K** – Giving **KNOWLEDGE** and Information to the Patient

Preferably, the patient should be told of the diagnosis and prognosis truthfully in plain language but not too bluntly. For example, telling a patient, “you have breast cancer and unless you get treatment you will die,” would be anxiety-provoking and inappropriate. Often times, it is good to give a ‘warning shot’ as an indication that bad news may be coming. Good examples of this include statements such as, “the test results just came back and we’re not too happy about it,” or “your chest X-ray doesn’t look very good.” This simple technique prepares the patient for subsequent worse news.¹¹

It is vital to start at the same level of comprehension and vocabulary as the patient. The clinician should try to refrain from using technical

jargon or euphemisms. For example, the term ‘spread’ may be less intimidating than ‘metastasize’ and ‘tissue sample’ could be used instead of ‘biopsy.’

Finally, when prognosis is poor, intimations that “nothing can be done” should be avoided. Even if a disease is too far advanced for curative treatment, the patient should be reassured that support will be provided to make his or her remaining life as comfortable as possible. Many terminally ill patients fear that once all forms of treatment have been exhausted, they will be abandoned by their doctor. This does not have to be the case.⁸ When interventions are limited to palliative measures, it is vital that doctors do not suggest that these actions are intended to cure the disease or, more importantly, allow patients to make that presumption.

Step 5: **E** – Addressing the Patient’s **EMOTIONS** with Empathic Responses

This is perhaps the toughest part of breaking bad news. The phases of emotion a patient experiences when he or she receives bad news ranges from denial to fear, anger, sadness, self-pity, dependency and hopelessness.

In this situation, the physician can support the patient with empathic responses. This can be done firstly by observing the emotion of the patient, whether it is tearfulness, sadness or shock. The next step is to identify and name the emotion experienced by the patient. For example, if a patient becomes upset or shows anger, the physician should indicate that he has recognized the emotion by suggesting, “I can see you are frustrated with all these tests and treatments,” or “you must be pretty angry with the situation you are going through right now.” Naming the emotion, even if wrong, will show that the physician is attempting to understand what the patient is going through. In addition, it would be good for the physician to try to identify the reason for the emotion. Usually, it is connected to the bad news. Finally, it is wise to give the patient time to express his or her feelings and let the patient know that the physician has connected the emotion to the reason for the emotion. The following example has been excerpted from Baile *et al*:²

Doctor: I’m sorry to say the X-ray scan shows that the chemotherapy doesn’t seem to be working [pause]. Unfortunately, the tumour has grown.

Patient: Oh no! I've been afraid of this! [cries]

Doctor: [Moves chair closer, offers patient tissues, and pauses]. I know this wasn't what you wanted to hear. I wish I had better news.

In the dialogue above, the doctor showed that he or she understood the patient's feelings by making a statement that reflected his understanding.

It is important to validate the patient's feelings or to give reassurance that it is okay to feel the way they feel. Comments such as, "I see why you feel that way," or "it appears you thought things through very well," are good examples of validation of a patient's emotional state. If unsure of how the patient is feeling, exploratory questions such as, "tell me more about it," or "could you explain what you mean?" or "could you tell what you are worried about?" can yield valuable insight into a patient's emotional state.

Step 6: S – STRATEGY and SUMMARY

Having a clear plan for the future will help the patient feel less anxious and more in control of his or her life. Before initiating a treatment plan, it is important to find out if the patient is ready for such a discussion. Any further discussion regarding treatment details does not have to take place at the time of the original consultation. Thus, it is important to schedule a follow up meeting on a fixed date and to ask the patient or family members to write down any questions they might have so that they can be answered later.

Legally, a physician is obliged to present the treatment options available and give advice on which course to follow. This must be in accord with the patient's wishes. Sharing responsibility in decision-making may reduce the sense of failure of the physician should the treatment be unsuccessful.

Often times, clinicians are apprehensive to discuss treatment and prognosis when they have unfavourable information. This is because they are uncertain about the patient's expectations. They fear destroying a patient's hope, fear feelings of inadequacy in facing an incurable disease and sometimes even feel embarrassment in having been too optimistic earlier in the treatment course.²

It is important for the physician to document all communications with the patient and family members, as well as the patient's reaction to the news. The physician should be concise and include the information in the patient's medical record.¹² This will ensure consistent information is available for all healthcare personnel involved in patient care.

Should a patient have unrealistic expectations, it may be useful to ask the patient to describe the history of the illness. This usually reveals fears, concerns and emotions that lie behind the expectations. Patients may look at cure as a way of solving different problems that are significant to them. This can range from loss of a job, an inability to care for family, loss of independence and mobility, pain and suffering and inflicting hardship on others. Expressing these concerns will help the patient acknowledge the seriousness of their condition.

CONCLUSIONS

The SPIKES protocol is a flexible approach which allows the patient to lead. Its implementation allows the clinician to be guided by the patient's understanding, preferences and behaviour. Approached in this way, this system is more likely to address differences between patients and avoid the use of a rigid recipe that is applied everyone.

It is important for the physician to remember that failure to cure is not the same as failing the patient, as palliation and good communication are also therapeutic. Physicians should be aware of their own well being and emotional state and be prepared for the possibility of patients taking their frustrations out on their physicians upon receiving bad news. Finally, while empirical data regarding patient preferences have been provided, doctors should not rely on them too heavily, as every patient is an individual. Doctors should feel competent to use their own intuition on methods taken to break bad news. Nevertheless, basic skills such as those mentioned in the SPIKES protocol should be taught to doctors as it serves as a very useful framework from which they can work.

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