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Editorial

How to Break Bad News

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Editorial

Bad news is defined as any information that adversely and seriously affects an individuals view of his/her future life.

Unfortunately it is being observed that majority of medical professionals are either not being properly trained or practice it appropriately in clinical practice. The biggest mistake doctors make when communicating bad news is reverting to "just-the-facts" mode as a defense against their own unease at giving unwelcome news. That defensiveness often leads to a lack of empathy for the patient or a "data dump" giving too much information, which can be difficult to retain under even the best circumstances.

Breaking bad news is also a complex communication task. In addition to the verbal component of giving the bad news, it also requires other skills. These include responding to patients' and attendants' emotional reactions, involving the patient or attendant in decision-making, dealing with the stress created by patients' expectations for cure, the involvement of multiple family members, and the dilemma of how to give hope when the situation is bleak.

In 50% of the cases, close relatives request not to disclose the news to patient. However many patients desire accurate information to assist them in making important quality-of-life decisions. Anyhow the decision varies from case to case.

Described below is the recommended 6-steps protocol named "SPIKES" which has been shown to improve clinicians' confidence when used to break bad news to seriously ill patients or to the close relative of the patient.

The Six Steps of Spikes

- Setting up the interview.
- Assessing the patient's Perception.
- Obtaining the patient's Invitation.
- Giving Knowledge and information to the patient.
- Addressing the patient's Emotions with Empathetic response.
- Having a Strategy and Summarizing.

Step 1: S-Setting up the Interview

Never hurry in disclosing the bad news, sketch the plan, and be prepared for any type of harsh response from the patient or from his close relative. As the messenger of bad news, one should expect to have negative feelings and to feel frustration or responsibility.

Select that room that is away from ward. Have tissues ready in case the patient starts crying.

Better to have some close relative beside. Sit down beside the patient or the one whom you are disclosing the news. Sitting down relaxes the listener and is also a sign that you will not rush. When you sit, try not to have barriers between you and the patient. Maintaining eye contact may be uncomfortable but it is an important way of establishing rapport. Touching the patient on the arm or holding hand is another way to accomplish this. Turn your cell phone or pager on silent mode. Never ever rush out of the room until the listener has settled down even if he/she said something that hurts you. Try to feel the psychological trauma that he/she is experiencing.

Step 2: P-Assessing Patient's Perception

Introduce yourself. Spend some time building rapport with the patient. Once you feel the patient is at ease, initiate discussion by asking the patient what he/she knows about his/her medical history, this could be done by asking such questions as;

1. What do you know regarding your illness?
2. What could be the probable cause of your illness?
3. Do you think the symptoms are serious or not?
4. What did the other physician inform you regarding your illness?

These questions would help you to assess patient's level of understanding regarding his/her illness.

Step 3: I-Obtaining the Patient's Invitation

Await invitation from the patient to give information. Ask patient if he/she wants to know the details of his /her medical condition and/or treatment as well as how much he/she wishes to know. It is important that physician maintains eye contact with the patient to explore patient's expectations as well as interpret

patient's nonverbal signals (face and body language).

If patients do not want to know details, offer to answer any questions they may have in the future or to talk to a relative or friend.

Step 4: K-Giving Knowledge and Information to the Patient

Bad news should never be given over the telephone. Decide on the agenda before you sit down with the patient, so that you have the relevant information at hand. Use the language that is understandable by the patient. Take into account patient's emotional status, educational level and sociocultural background. Avoid giving all of the information in one chunk, share the information gradually in chunks. Pause frequently and check frequently patient's feeling and understanding. You could do it in subsequent visits as well. Respond to patient's reaction in an optimistic way. Give any positive aspects first, e.g., cancer has not spread to lymph nodes, highly responsive to therapy, treatment is available locally, etc. Give facts accurately about treatment options, prognosis, costs, etc., BUT always try to keep a hope and faith that whatever would be the outcome thatwould be the best for you.Avoid bluntness (e.g., "You have very bad cancer and unless you get treatment immediately you are going to die.") similarly when the prognosis is poor, avoid using phrases such as "There is nothing more we can do for you."

Step 5: E-Addressing Patient's Emotions with Empathic Responses

Different people respond to bad news differently, some cry, some get angry, some become deeply sad etc. Respond in a way that demonstrates that you are deeply concern about his health and life. Try to build his will power. Responding to the patient's or close relatives' emotions is one of the most difficult challenges of breaking bad news. Their emotional reactions may vary from silence to disbelief, crying, denial, or anger. Outbursts of strong emotion make physicians uncomfortable but always try to imagine yourself in place of the patient or the close relative with whom you have shared the news.

Clinicians can also use empathic responses to acknowledge their own sadness or other emotions ("I also wish the news were better or I will try to help you, hope and pray for the best"). It can be a show of support to follow the empathic response with a validating statement, which lets the patient know that their feelings are legitimate.

Step 6: S-Strategy and Summary

Physician must summarize all that has been said and plan for the future plans such as performing additional tests, arranging referrals, setting up follow up visits, discuss potential sources of emotional support among family or friends etc. Ask patient whether they want something else clarified. Sharing responsibility for decision-making with the patient may also reduce any sense of failure on the part of the physician when treatment is not successful.

If patients become emotionally upset in discussing their concerns, it would be appropriate to use the strategies outlined in step 5 of SPIKES. Second, understanding the important specific goals that many patients have, such as symptom control, and making sure that they receive the best possible treatment and continuity of care will allow the physician to frame hope in terms of what it is possible to accomplish. This can be very reassuring to patients.

Some physicians contend that breaking bad news is an innate skill, like perfect pitch, that cannot be acquired otherwise. 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.

Focus on reassurance and ongoing support with phrases such as: "Whatever happens, we won't let you down, you will not be left to face this on your own"; "I will be with you all the way"; "We will look at your options and work on this together".

If at any stage you observe that patient fall silent and is totally unable to respond, try to encourage discussion with something positive as I will try my best or let's hope for the best etc. but if all your attempts to stimulate discussion are unsuccessful, or if it shows that patient needs more moral support and time, it may be better to reschedule meeting on some other time. Denial is a healthy defense mechanism.

Lastly doctor needsto gain trust of his/her patient in order to have an effective reassurance. This can be done verbally and nonverbally. Verbally use positive comments, e.g., 'it is your right to feel this way, "I will do my best to deal with this problem, I am your doctor you can call me anytime, helping you is my obligation"etc. To touch the patient is the only nonverbal reassurance, e.g., by holding patient's hand while talking, doing a physical examination gently with a positive comment at the end and to shake hand etc.

You can help your patients hope for the best while also preparing them for the worst. Acknowledging that these two apparently conflicting emotions can co-exist gives you the opportunity to explore hopes and concerns and signals that you are willing to discuss both.

This is an area in medical practice that needs a lot of skills and practice.

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