Breaking Bad News

Communicating a Difficult Diagnosis or Lifestyle Change

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What makes these conversations so difficult?

Can you recall stories?

What factors may prevent these conversations from taking place?
Often thought of in regards to cancer, but it’s NOT just cancer.

Breaking bad news includes many more situations than “telling patients that they have cancer.” Most new diagnoses, especially chronic ones like dementia, stroke, multiple sclerosis, angina, end stage heart failure and COPD represent significant bad news… and the following principles apply.

Primary vs. Secondary Bad News

Many patients with cancer have told us that the initial diagnosis of cancer (primary bad news) was not as bad as the “secondary bad news” (i.e. that, after cancer therapy, cancer remained.)

“Breaking Bad News” article:
Breaking bad news: advice for hospital doctors
7 April 2006 BMJ-Learning

Abstract for “SPIKES – A six-step protocol for delivering bad news.”
This model focuses attention on understanding the patient’s response and dealing appropriately with this moment.

Remember: Before sharing information, focus on the patient.

The patient-centered model for Breaking Bad News

1) Advance planning & what to say at the beginning
2) Forecasting and delivering Bad News
3) The PATIENT response
   A) Feelings, Perspectives, and Experiences
   B) Meta-communication: discussion on how best to proceed – Agenda, Readiness, and Preferences
4) Deliver information (after completing the above)
5) Establish common ground strategy – summarize
   A) Check for understanding (ask-tell-ask), feasibility, and mutual responsibilities
Two important points from this model...

1) Breaking Bad News and dealing with the patient’s response should be distinct moments that are separate from the sharing of therapeutic information.

2) The patient’s personal response and preferences should be at the center of this approach.

What can happen if you move too quickly from breaking bad news to sharing information?
Step 1: Advance Planning

1) Get your ducks in a row (assemble results, labs, talk with consultants, and/or search literature).

2) Anticipate questions (especially the question, “Are you sure?”). Find answers ahead of time.

3) Select setting for follow-up visit, and plan in advance for whom the patient wants present. Ideally, make these arrangements when the test is ordered or performed (not when the results come back).

Why is it so important to follow this portion of the model?
Step 1: Advance Planning
Preparing for the visit

A central principle in cancer communication has been an assumed value in being present with the patient at the moment of Breaking Bad News.

However, this approach is not universally favorable to all patients.

How could advance planning, specifically meta-communication about how to share test results, be helpful?

Not certain how to initiate this advance planning? How might you incorporate aspects of meta-communication into your own practice?
Step 1: Day of the visit
What to do before BBN?

Begin by addressing the patient’s comfort and, if relevant, expressing interest in how the “procedure” went. These comments maintain relevance to the patient’s situation.

Why is it advisable to explore what the patient has been told or observed about the results?

How could you go about investigating a patient’s previous knowledge?
Step 2: Forecasting with care, Delivering with clarity and hope

To do:

• **Forecast** - Even the briefest of time of *forewarning* can allow the patient to brace themselves and prepare for the news to follow.

• Be honest.

• Express concern and sympathy for the patient. E.g. “I’m sorry but the news is not what either of us would want.”

• Be clear and un-ambiguous. Avoid euphemisms and jargon.


• Express a commitment to “be there.”

How might you put expressions of concern and sympathy into your own words?
What about your feelings?

Having personal feelings about the situation is normal and desirable. Self-disclosure or your own tears become problematic **IF** they re-focus the attention on the clinician.

What are your thoughts and reflections on this point?
Step 2: Forecasting with care, delivering with clarity and hope

What To Avoid:

• Bluntness and statements devoid of hope

• Use of jargon, which confuses and may mislead

• A game mentality – good news/bad news (see next slide)
Good News/Bad News?

About 10% of our participants reported remembering (usually critically) a good news/bad news approach.

Can you think of a time that a “good news/bad news approach was used”

How might you have delivered the bad news differently?
What would you say to Break Bad News?

Take a moment and write the exact words you would use to tell a patient about a secondary bad news diagnosis.

The clinical situation: Your patient was recently diagnosed with colon cancer that showed up on colonoscopy after a bleeding episode. She seemed to take that news without too much distress. She returns after staging procedures that included a CT scan and laparoscopic surgery. Results showed spread through the bowel wall with attachment to pelvic bones. There are also other areas of pelvic spread. Prognosis is poor with only a 2-4% 5 year survival.
Pair and Share
Breaking Bad News
Step 3: Focus on the patient

1) Advance planning & what to say at the beginning
2) Forecasting and delivering Bad News

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3a: Eliciting Feelings and Perspectives – Some approaches to avoid.

NOT RECOMMENDED
For example, after stating that “I’m sorry to have to tell you but the diagnosis is… cancer and you are going to need chemotherapy and radiation followed by surgery.”

What would you say or do to focus on the patient’s response?
There are approaches providers take that can avoid patient’s feelings and emotions.

The clinician may ignore the patient’s non-verbally expressed angst. By moving to treatment recommendation the doctor puts a lid on the patient’s feelings.

A provider may ask cognitively focused questions such as “Do you have any questions?” and “What do you know about colon cancer? Such questions typically divert the discussion from feelings to knowledge.

How might telling a patient “Don’t worry, it’s going to be OK.” discourage expressions of feeling or provide false reassurance?
3a: Eliciting Feelings and Perspectives. How is it done?

RECOMMENDED:

Stop talking and verbally and/or non-verbally shift to the patient
- Use Touch and Silence with facilitating gestures
- Ask directly about patient’s response
- Ask patient’s communication preference (meta-communication)

How would you use these methods in a patient encounter?
The use of SILENCE has considerable merit. It gives the patient some time. It demonstrates interest in the patient’s response, but does not direct the patient to a particular manner of response. TOUCH can be useful.

NORMALIZING the fact that people are frequently or usually upset and then focus on individual reactions and what may be of most concern to that particular patient.

META-COMMUNICATION starts when the clinician begins to talk about the various patient preferences for communication and normalizes all of those approaches (EQUIPOISE) while providing an opportunity for the patient who wants to respond to do so.
You have just told a patient that she has colon cancer. Her response is a shocked stare, but she says nothing. You want to provide an opportunity to focus on the patient’s response/needs.

In your own words write what you would say and what you would do to focus on this patient’s response.
Pair and Share
Oftentimes, patients imply or suggest their concern rather than directly expressing the source of their distress. Such clues may be ignored and their underlying meaning may be missed.
Actively Listening for Clues

Recognizing clues and exploring them further takes you to a very different place. An effective way to begin Active Listening is to repeat a person’s “charged words or emotional expression.”
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How do providers demonstrate ACTIVE LISTENING?
How strong are a patient’s feelings after Bad News is delivered? Do they want to talk about these feelings?

What do patient’s reveal about the importance of meta-communication?

From what we hear from cancer patients:
~ 80% experience feelings that are strong/overwhelming.
~20% want to talk about them—at that moment.
Patient responses:
Question to Consider

Why might patients experience strong feelings yet prefer not to discuss them?

• Defense mechanisms keep the feelings controlled.
• Looking for good news in terms of treatment to get control of overwhelming feelings…
• Not wanting to look silly/weak in front of doc or family.
• Other
Questions to Consider

How would you respond if the patient chooses not to discuss feelings?

How might you respond to this patient after she says, “Go on”? (Wit, 2001)
After addressing initial personally charged response, plan an approach to sharing information…

**Recommendations TO DO:**

- Ask about patient’s agenda, now
- Explore who should be present for information and when is best to proceed
- Try meta-communication. What’s that? Meta-communication is defined as talking about communication wishes, i.e. exploring the patient’s preferences for communication style/content; information directness and detail; preference for discussing or not discussing prognosis & timeline, etc.
- Discuss preferences for decision making
• **Recommendations NOT to Do:**
  – Assume you know what this patient wants to know
  – Develop a one style fits all approach

Kaplowitz article on “What patients want to know.”
Step 4: Delivering Information

Tailor the information to the patient’s preferences:

- Use the “Ask-tell-ask” approach.
- **ASK:** Establish the existing level of knowledge and questions. This is the best way to discover misconceptions.
  - “To begin tell me what you know about…” Then later, “What initial questions do you have?”
- Ask-**TELL**-ask: Remember the importance of simple and clear messages.
  - Present info as “Pros and Cons.”
Step 5: Establish Common Ground

- **Ask-tell-ASK:**
  - **Check for understanding.** “I’d like to make sure I’ve been clear. Can you tell me how you will explain what we’ve just talked about to someone in your family?”
  - **Check for buy-in.** “How does that sound?”
  - **Check for feasibility and obstacles.**
  - **Define patient responsibilities and physician responsibilities.**
Breaking Bad News - What cancer patients have taught us.

- Secondary Bad News (treatment failure) is often worse than initial diagnostic bad news.
- Expressions of physician concern are appreciated.
- Many patients experience emotional angst with receiving Bad News yet many prefer not to talk about it at the time of diagnosis.
- Most patients appreciate being offered the opportunity to address feelings (even if they choose not to).
- Patients want different amounts of data, prognostic detail, and honesty or hope. Most patients are willing to talk about what they want and don’t want.
You have just informed the patient that she has somewhat advanced colon cancer and that she will need chemotherapy and radiation...
ISSUES OCCURRING IN PREPARATION FOR BREAKING BAD NEWS

• Pre-planning for the visit
• How to begin. What is appropriate and what is not.
• Discussing what the patient has been told/knows

ELEMENTS OF DELIVERING BAD NEWS

• How best to preface and forewarn “bad news”
• Should you share your own feelings? E.g. “I’m really sorry to be the one to give you some bad news.”
• Clarity and Honesty
• Auspicious (favorable or up-beat) Interpretation
• Commitment to “be there”
Issues that were addressed

PATIENT’S RESPONSE TO BAD NEWS, AND RECOMMENDATIONS FOR PROCEEDING

• What to do after sharing the bad news
• How to deal with feelings and concerns when expressed and when not expressed
• Listening for and exploring patients’ clues to their concerns and issues
• Determining the patient’s “thirst for information”, agenda, decision making preferences

SHARING INFORMATION: Ask-Tell-Ask

• Asks – what patient knows
• Tells – information following patient’s stated preferences.
• Tells – options organized by Pros & Cons
• Asks – about understanding using “Tell-Back Approach”

REACHING COMMON GROUND

• How to determine patient’s preference for decision making
• How to elicit/incorporate patient’s values
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Thank You