Breaking Bad News

DR KATHERINE MILES

Learning Objectives

Breaking bad news in the context of ethical principles

Principles of breaking bad news – the SPIKES tool

Consultation skills in breaking bad news

Current Jordanian research on breaking bad news and doctor's learning needs

Introducing the concept of palliative care

Case based discussion

What is Bad News?

Serious or life threatening diagnosis e.g. cancer, lifelong diagnosis or chronic disease – heart failure

Social taboo e.g. HIV infection or epilepsy

Disease or illness that may affect fertility

Different people have different views about what is “bad news”

Terminology changing from “breaking bad news” to “sharing difficult news”

Reminder of Ethical Principles

Patient autonomy *(patient choice on receiving information)*

Patient consent *(regarding their information and sharing of it)*

Patient confidentiality *(right to privacy and choosing who they share their information with: doctor bound by patient confidentiality)*

Non-maleficence *(do no harm to your patient)*

Beneficence *(do good to your patient)*

Justice *(doing right by society)*

Principles of Giving Bad News

Things to avoid:

Breaking patient confidentiality

Collusion with relatives (the relatives know the diagnosis but the patient doesn’t)

Assuming it is best for patients to not know the truth

Principles of Giving Bad News: SPIKES Tool

Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP (2000) SPIKES – A Six Step Protocol for Delivering Bad News: Application to the Patient with Cancer. Oncologist 5:302-311

Consultation Skills for Giving Bad News

SETTING: Preparation – prepare yourself with the information, patient (and if has relatives), found ideal location and no interruptions

PERCEPTION: Assess base level of knowledge: What does the patient know?

INVITATION: Assess amount of information to give: What does the patient want to know? How much? Even if bad news? Warning shot: 'I'm sorry I have some bad news'

Consultation Skills (Continued)

KNOWLEDGE: Give information in chunks

Check understanding

Pause, allow time

EMPATHY: Allow denial, expression of feelings and listen to concerns – listen, don't interrupt

Use empathetic statements e.g. 'I can see how upsetting this is for you', 'I can understand how you felt that way'

SUMMARY / STRATEGY: Summary and plan

Offer availability

Stages of Grief

Denial – trying to avoid

Anger – frustrated outpouring of emotion

Bargaining – seeking for a way out

Depression – realization of the inevitable

Acceptance – finding a way forward

Kübler-Ross, E. (1969). On death and dying. New York, NY: Macmillan.

Jordanian Research

Identified learning needs for Jordanian doctors breaking bad news to patients and relatives:

Consent, autonomy and confidentiality:

- Perceived occurrence that the doctor gained the patient's consent before telling others the diagnosis was 35.7%

First disclosure:

- 25.4% of patients received the diagnosis according to their preference

Withholding information:

- Greatest challenge for 62.1% of doctors was the relatives not wanting the patient to know the diagnosis
- 93.2% of patients said they wanted the doctor to tell them the diagnosis even if relatives had asked the doctor to withhold it

Jordanian Research (Continued)

Specific Communication Skills:

- Empathetic attitude
- Using a warning shot (considered to lessen the potential emotional reaction)
- Using physical touch appropriately (considered a learning need for doctors)
- Ascertaining the importance of faith for patients / relatives and using religious phrases appropriately (this differs from the Western model of SPIKES)
- Managing moments of patient / relatives aggression
- Offering appropriate follow-up (this was perceived as a weakness in doctor's plan of action currently)

IGAD Framework (Salem & Salem 2013)

I – Interview: ask the patient if they would like relatives present and facilitate this

G – Gather: gather information on the desired level of disclosure a patient wants

A – Assess, Achieve: assess religious and family influences, achieve rapport

D – Decide, Disclose, Discuss: decide on the appropriate level of disclosure, disclose information slowly and simply, discuss and summarise

What is Palliative Care?

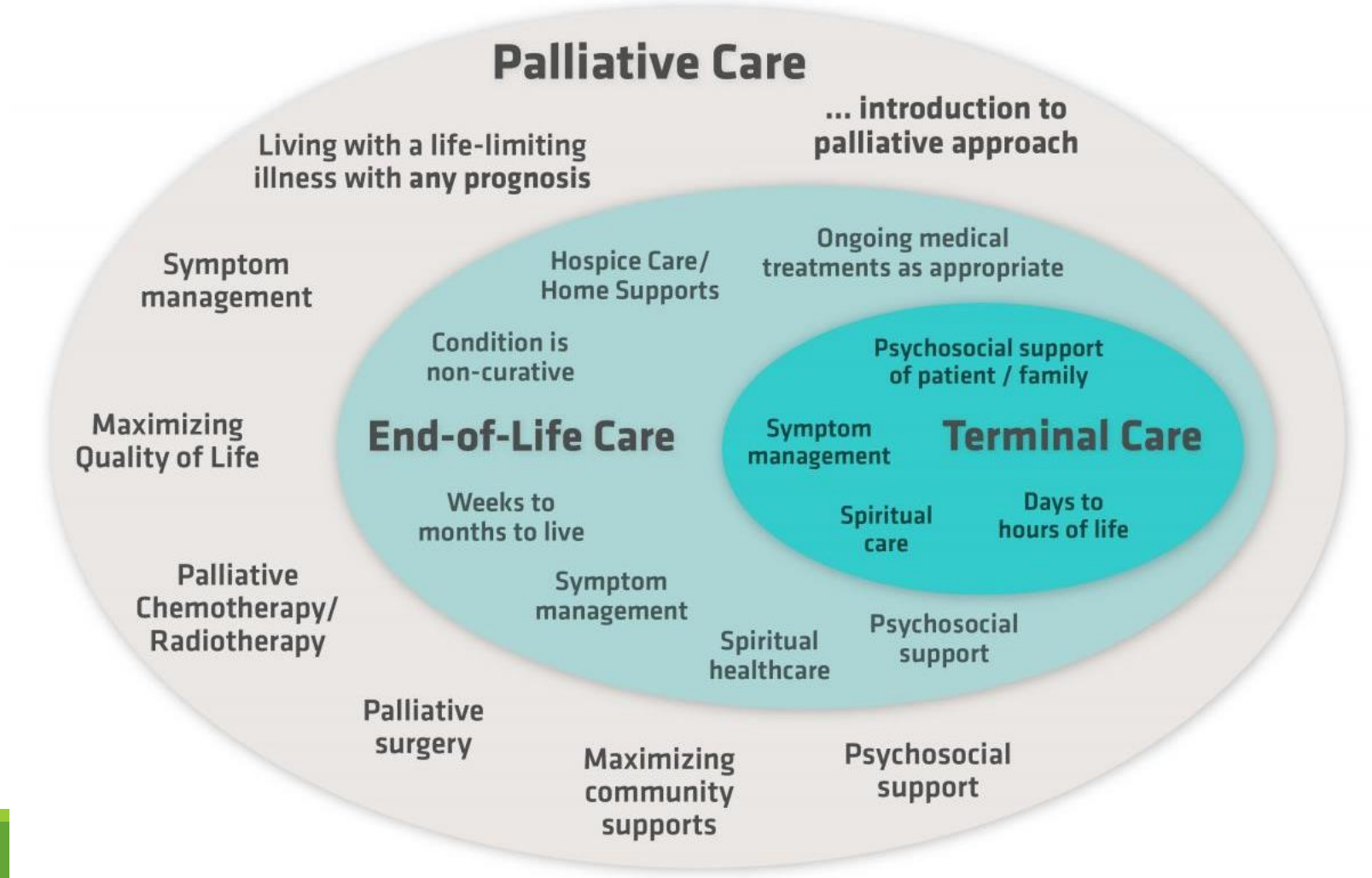
Speciality that cares for the dying or with a terminal diagnosis that will not get better e.g. cancer, end stage disease like heart failure. First hospice set up in 1967 (a place where patients can die well in peace and are as symptom free as possible)

Philosophy is that the focus is dying and we are not actively trying to `cure' or `save' the patient. May put them as `do not resuscitate' or stop active cancer treatments unless helps symptoms

Patient centred and holistic – look at physical, psychological and spiritual elements of care for the patient

Manage symptoms e.g. pain, breathlessness, nausea and vomiting…

Phases and Layers of Care



Resources

Silverman J, Kurtz S, Draper J. - Skills for Communicating with Patients

Douglas G, Nicol F, Robertson C. - Macleod's Clinical Examination

www.dummies.com/health/basic-principles-of-medical-ethics

www.oscestop.com/Breaking_bad_news.pdf

www.thepalliativecarehub.com/introduction-palliative-care

Acknowledgements

Special thanks to Dr David Harniess for his help in preparing this lecture