Delivering Bad News

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Introduction

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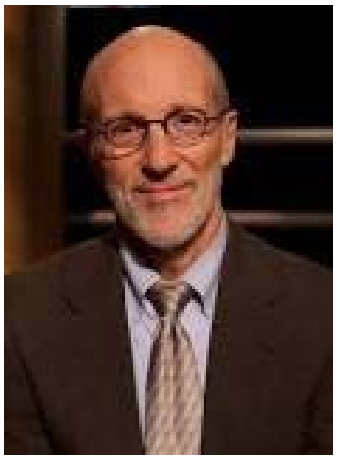

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Timothy E. Quill, MD

- Thomas and Georgia Gosnell Distinguished Professor in Palliative Care at the University of Rochester Medical Center (URMC)
- Professor of Medicine, Psychiatry, Medical Humanities and Nursing at URMC
- Founding Director of the URMC Palliative Care Division and a Past President of the American Academy of Hospice and Palliative Medicine
- Published and lectured widely about various aspects of the doctor-patient relationship, end-of-life decision making, delivering bad news, discussing palliative care earlier, non-abandonment, & exploring last-resort options
- Author of several books on end-of life - Physician-Assisted Dying: The Case for Palliative Care and Patient Choice (Johns Hopkins University Press, 2004), Caring for Patients at the End of Life: Facing an Uncertain Future Together (Oxford University Press, 2001), A Midwife Through the Dying Process: Stories of Healing and Hard Choices at the End of Life (Johns Hopkins University Press, 1996) and Palliative Care and Ethics (Oxford University Press, 2014)
- Author of over 150 articles published in major medical journals
- Lead physician plaintiff in the New York State legal case challenging the law prohibiting physician-assisted death that was heard in 1997 by the U.S. Supreme Court (Quill v. Vacco)

Delivering Bad News - Definition

Drastically and negatively alters a person's view of the future

May depend on the meaning attached by each individual patient

Potential for differing perceptions of physicians and patients

Why is it so difficult to deliver bad news?

- Many physicians have never been trained
- Discomfort with strong emotion
- Desire to protect the patient
- Desire to soften the bad news
- Feels like we are harming the patient

Basic Communication Skills:

Underlie many important encounters…

1. **Attend to beginnings**
2. ***Ask Tell Ask* –** for delivering difficult information
3. **Wish statements –** to respond to disappointing news
4. **Respond to emotion –** for compassionate response
5. ***Tell Me More* –** for deepening understanding
6. **Involve others -** family members and other medical providers

1. Attend to beginnings:

Advance Preparation

Prepare yourself – Confirm facts; plan agenda

Choose appropriate settings – quiet, private, protect time

Identify who should be present – key family and key clinicians

Briefly "huddle" before going in…

- *Agree on the agenda*
- *Relevant history of prior interaction with family?*
- *Who will lead the meeting?*

1. Attend to beginnings:

Getting Started

Lead communicator – introduces him or herself

- Ask family to introduce themselves
- Ask clinical team members to introduce themselves

Attend to immediate patient/family comfort

- *"How are you feeling right now?"*
- Respond immediately to obvious discomfort

Set the agenda

- *"We would like to talk with you about the results of …"*
- *"Are there additional concerns you would like us to address?"*

1. Attend to beginnings:

Getting started (continued)…

Have patient / family talk first about what they already know

- *"How does (s)he seem to be doing in your eyes?"*
- *"What have you been told so far?"*

Make "contact" with all core family members in the room

- *"We have heard from A; do you see things the same way?"*
- *"Are you all on the same page in this regard?"*

Reconcile differences in understanding between family and staff

- *"His basic blood pressure and heart rate have stabilized right now…"*
- *"She has been a bit more responsive with our staff.."*

Make sure the patient / family are ready to move forward…

- *"Would it be helpful for us to share what we know so far?"*
- *"Are you ready to talk about the biopsy results…"*

2. A process for delivering new information:
Ask–Tell–Ask

Ask - if they are ready to talk about the test results

Tell - information in small amounts; build on what they know

Ask - what do they understand; would they like to hear more

Repeat the cycle as many times as is needed

2. Ask–Tell–Ask

Caveats

Physicians tend to *Tell* too much information at once

- If you are talking too much, **stop** and ***ask*** what has been heard

If patient/family is overwhelmed with emotion

- *Telling* further information at this point will not be processed
- Shift to emotion management strategies

If the visit is all questions for the clinicians but no emotion

- Suggest that *they may have strong emotional reactions in the future*
- Offer to explore these reactions should they desire to

3. Responding to Emotion

- Strong emotions are frequent in these medical interactions
- Most clinicians are more comfortable with information than emotion
- Basic emotion management skills are easily learned and applied
- Responding to emotion is time efficient in the long run

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3. Responding to Emotion

Acknowledge – "*You seem frightened (sad, upset, angry*…)"

Legitimize – "*Anyone in your shoes would be (frightened*)…"

Explore – "*Tell me more about the most frightening part*…"

Empathize (if you genuinely feel it) - "*That certainly sounds frightening*"

Support – "*We will work through this together.*"

4. Caveat for responding to disappointing news:
Using wish statements

"I wish I had better news for you…"

"I wish medicine was more powerful than it is…"

"I wish we had more options than we do…"

"I wish things had turned out better…"

What underlies *wish* statements?

Ambiguous statements

- Reframes what is hoped for as a wish
- Acknowledges that what is hoped for will likely not happen

Empathic statement

- Identifies with what the patient is unrealistically hoping for
- Puts that hope in a more realistic frame

Must be followed by

- Emotion management
- Planning for what comes next

5. “Tell me more…”

A strategy for deepening understanding

Using the patient’s own language to deepen understanding

“Tell me more about *the most upsetting part”*

“Tell me more about *what was worrying you the most”*

“Tell me more about *what made you most angry”*

5. "Tell me more…"
A strategy for deepening understanding

Deeper understanding can be the basis for empathic statements

- *"Now I really have a sense why it was so (distressing) to you"*
- *"I can imagine that I would react similarly in your shoes"*

Generally followed by a re-commitment to follow through

- *"We will work hard with you to find an approach that makes sense"*
- *"We will help you sort out next steps"*

Repeat the request to "*tell me more*" until you really understand

6. Involve family members…

If key family members were not there, make a plan for informing

- *"How should we go about informing his (children)?"*

Who from the family should be with us when we talk to (the patient)?

- *"Who do you think should go with us when we talk to ___ ?"*

Evaluate requests that some family members not be told.

- *"His grandmother is very frail; I don't think she could handle it."*
- *"I don't want his father to be told; he is a severe alcoholic."*

…other members of the clinical teams

- Inform nursing staff what the patient/family knows
- Inform other clinical teams of new information/decisions
- Ensure differences are initially discussed away from patient/family

Make a plan for follow-up

Establish a plan for the next steps

- *"I would like you to see a cancer specialist."*
- *"Why don't we meet again later this week."*

Ensure the patient has adequate support

- *"Is there anyone who can be with you?"*

Reassure that patient will not be abandoned

- *"We will work together to find the best path."*

Assess the patient's safety

Case Presentation

MEDICINE *of* THE HIGHEST ORDER

UNIVERSITY *of* ROCHESTER MEDICAL CENTER

Case Presentation

- 60 year old man had symptoms of peptic ulcer disease and was found to have a gastric ulcer
- He was told that a biopsy needed to be done, because there was a “tiny chance” it could be gastric cancer
- The biopsy did show gastric adenocarcinoma
- You now have to give him the news

How to get prepared?

Your own reaction?

Medical facts

- 5 year survival 5-15%
- Cure unlikely (unusual to diagnose before it has spread)

Next step is Abdominal CT scan

Surgical and medical oncology consults

How is this going?

- What has she done well?
- Which recommended steps were followed so far?
- What are the biggest challenges so far?
- Were there major things you would do differently?

Things to consider trying…

Experiment with these techniques in your real practice

- *All kinds of bad news discussions in medical practice*

Have trainees/colleagues observe you, or you observe them

- Give feedback and ask for feedback
- Always identify something done well and something to improve

Read the brief articles associated, if you have not yet done so

General References

Required short reads

Back, Arnold Tulsky et al. Fundamental Communication Skills; Oncotalk Module 1; https://depts.wahington.edu/oncotalk/learn/modules.html

Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. Oncologist 2000;5:302-11.

Additional recommended reads

Quill TE, Arnold RM, Platt F. "I wish things were different": expressing wishes in response to loss, futility, and unrealistic hopes. Ann Intern Med 2001;135:551-5.

Back AL, Arnold RM, Baile WF, Tulsky JA, Fryer-Edwards K. Approaching difficult communication tasks in oncology. CA Cancer J Clin 2005;55:164-77.

For More Information

DocCom Module 33: *Delivering Bad News*

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