Breaking the Bad News; Tools for Critical Conversations.

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Pause and Reflect …

Think of the last time you needed to give someone life-limiting news or had a family conference regarding a very ill loved one.

– What thoughts and feelings did you have prior to and following the discussion?
– What was uncomfortable about the experience?
– Did you feel that you, the patient, or the caregiver benefited from the experience?
What is “Bad News”

“Any information which adversely and seriously affects and individual’s view of his or her future”


Breaking Bad News: Why is it important?

- A frequent but stressful task
- Patients want the truth
- Ethical and legal imperatives
- Clinical Outcomes
The Physician as Messenger

Why Bad News is not always presented in a professional manner by physicians…

- Guilt: “I should have found the cancer sooner”
- Fear of provoking uncomfortable emotional reaction in patient or self: “What if I start crying”
  “What do I do if the patient starts crying”
- Fear of destroying hope: “I don’t want to take responsibility for taking away all hope”
- Lack of formal training

The Physician as Messenger (cont.)

- Resulting in …
  – half truths and misinformation
  – lack of clarity for appropriate goal setting
  – false hope
  – A more “negative” experience for the patient and clinician than is necessary
What do patients tell us …

- Patients almost always want direct, truthful information—when in doubt, ask!
- Patients find effective ways to cope with bad news—thus, physicians need not feel responsible for “destroying hope”
- Physician empathy and honesty will promote improved trust, clearer goal setting, and decision making.

Patients Benefit From End-of-Life Discussions With a Doctor

- Researchers interviewed 332 pairs of dying patients (all had advanced cancer) and their caregivers.
- 37% said they had end-of-life discussions with their doctor.
- Median time from enrollment to death was 4.4 months
- Caregivers’ psychological state and QOL was assessed 6.6 months after the patient’s death.

JAMA 2008; 300(14): 1665-73
Patients Benefit From End-of-Life Discussions With a Doctor

- Patients who had end-of-life discussions had lower rates of:
  - Ventilation
  - Resuscitation
  - Admissions to the ICU
  - Earlier enrollment in a hospice (which was associated with an improved quality of life).

JAMA 2008; 300(14): 1665-73

Patients Benefit From End-of-Life Discussions With a Doctor

- Caregivers were significantly less likely to experience major depressive disorders if the loved one did not die in the ICU.

JAMA 2008; 300(14): 1665-73.
When A Discussion is Recommended

- All patients with advanced progressive life-limiting illnesses should be given the opportunity to discuss prognosis and end-of-life issues.
- When there is a change in condition, or a perception of change by patients or caregivers

When A Discussion is Recommended (Cont.)

- When a treatment decision needs to be made
- If there are requests or expectations that are inconsistent with clinical judgment
- If disease-specific treatment is not working or there are complications from this treatment that limit its effectiveness
A Strategy Can Help the Physician and the Patient

- When physicians are uncomfortable they may avoid discussing poor prognosis or convey unwarranted optimism.
- Understanding a patient's values and wishes coupled with a strategy for addressing distress can increase the physician's confidence.

A Strategy Can Help the Physician and the Patient (cont.)

- It may encourage patients to participate in difficult treatment decisions.
- Physicians who are comfortable in breaking bad news may be subject to less stress and burnout.
Goals of the Bad News Interview

- Gathering information from the patient
- Provide intelligible information in accordance with the patient’s needs and desires
- Support the patient by employing skills to reduce the emotional impact and isolation experienced by the recipient of bad news
- Develop a treatment plan with the input and cooperation of the patient

Breaking Bad News-Key Steps

1. Prepare yourself
   - Facts: know as much as you can about the medical issues, anticipate questions
   - Find out what patient has been told by other health care professionals
   - Recognize limitations in your knowledge
   - Check your emotions—what feelings do you have about the patient and news that may impact how/what you say.

2. Check the environment
   - Sitting; Privacy
   - Ensure all relevant / requested parties are present
   - Turn off beeper/phone/television
   - Make a connection with the patient (e.g. eye contact)
3. Check readiness to receive information
   → Determine if any of the following are present:
     ✓ Cognitive deficits
     ✓ Pain or other symptoms that will interfere with understanding
     ✓ Extreme emotional disturbance

4. Determine what the patient already knows
   – “What do you understand about your condition?”
   – “What is your understanding of the reasons we did the MRI?”

5. Give a warning shot
   – “I’m afraid I have some bad news”
   – “The test results are not good”
Breaking Bad News-Key Steps (cont.)

6. **Present Bad News succinctly ..**
   - Speak slowly, deliberately, clearly
   - Avoid excessive bluntness
     - “You will die without aggressive treatment”
   - No medical jargon
     - “The tissue sample showed cancer”
   - Allow silence
   - Do not rush into further discussion

Breaking Bad News-Key Steps (cont.)

7. **Allow silence, give patient time to react and ask questions**
   - Count silently to 30-60; if patient does not speak, then ask: “can you tell me what you are thinking about”
   - Acknowledge and validate reactions prior to any further discussion; let patient lead to flow of discussion.
   - When prognosis is poor avoid phrases such as “there is nothing more we can do”.
Responding to Emotional Reactions

- Overwhelming emotion may limit further discussion
  - Crying
  - Anger: "the last doctor should have found this"
  - Numbness: "I don't know what to say, I'm numb"
  - Denial: "It's not me, the lab must have mixed up the specimens"

- Silence (active listening), empathy and validation of feelings, will help with most emotional reactions

Examples of Empathetic Responses

- “I can see how upsetting this is to you”
- “I can tell you weren’t expecting to hear this”
- “I am sorry that you have to hear this”
- “I know this is not good news for you”
- “This news must seem overwhelming to you right now”
Breaking Bad News-
Key Steps (cont.)

8. Invite questions
   • Be prepared to discuss prognosis and treatment options

Breaking Bad News-
Key Steps (cont.)

9. Make a follow-up plan
   – “make a list of questions, let’s meet again tomorrow to discuss further”
   – Clarify treatment decisions including non-curative treatments such as symptom control
   – Clarify your role in future medical care
Breaking Bad News-Key Steps (cont.)

10. Document
   – Who was present?
   – What information was discussed?
     • Test results
     • Prognosis
     • Treatment plans
   – What follow up is planned?

Assess Your Own Feelings Following the Encounter

■ Guilt
   – “This is my fault. I missed his early symptoms. I’m not supposed to cause emotional pain.”

■ Anger
   – “I wouldn’t be in this situation if she had come for regular check ups.”

■ Fear
   – “They are going to blame me for this.”

■ Sadness
   – “How can this happen to this person?”
Assess Your Own Feelings Following the Encounter (cont.)

- Seek out others to debrief your feelings
  - Attending or residents, fellow team members
  - Social workers, chaplains
  - Students, colleagues

Breaking Bad News by Telephone

- Avoid if possible
- Make sure you have time to talk
- Clarify who you are speaking to
- Introduce yourself and your role
- Give a warning shot
- Offer to meet at the hospital or your office to present the bad news
- Offer to contact others
Summary of Key Steps

1. Prepare yourself
2. Check the environment
3. Check readiness to receive information
4. What does the patient already know?
5. Give warning shot
6. Give bad news
7. Allow silence; respond to emotion
8. Invite questions
9. Make a follow-up plan
10. Document

References

Fallowfield, L. Giving sad and bad news. Lancet 1993; 341:476.
Wright, AA. Association Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment. JAMA 2008; 300(14): 1665-1673.
The Patient/Family Goal-Setting Conference

- Opportunity for shared-decision making process in establishing goals near the end of life
  - Patients/Surrogates want an opportunity to discuss the Big Picture
  - Can be emotionally volatile
  - Palliative Care’s “procedure”
Meeting leadership

- Leading a Family Conference should be thought of as a ‘team sport’ to include physician, nursing, social service, and chaplains, as dictated by the clinical situation.
- Skill set necessary for successful outcome
  - Group facilitation skills
  - Counseling/emotional reactivity skills
  - Knowledge of medical and prognostic information
  - Willingness to provide leadership in decision-making

Ten Step Process

- Clearly identified steps with a sequence designed to balance information flow, emotional reactivity, and foster shared decision-making.
- Process works equally well if the patient cannot participate and a surrogate decision maker is involved in the decision process.
Summary of Key Steps

1. Pre-meeting planning
2. Proper environment
3. Introductions/Build relationship
4. What does the patient/family know?
5. Medical review
6. Silence, respond to emotions
7. Present options
8. Managing conflict
9. Transform goals into a medical plan
10. Summarize and document

1. Pre-Meeting Planning

- Review medical history/treatment options/prognostic information
- Coordinate medical opinions between consultants/primary MD
- Obtain patient/family psychosocial data from care team members
- Review Advance Care Planning Documents:
  - Is patient decisional?*
  - Is there a Power of Attorney?
2. Environment

- Choose a Proper Environment
  - Quiet, comfortable, chairs in a circle
  - Invite participants to sit down
  - Check your personal appearance; turn off your beeper

3. Introductions - *Build* Relationship

- Introduce yourself, have participants identify themselves and their relationship to patient

- Identify the legal decision maker or family designated decision maker

- Review your goals; ask family if these are the same or different from their goals

- Establish ground rules
  - Everyone can talk
  - No interruptions
Introductions –
*Building Relationship (cont.)*

- For patients with whom you have no established relationship, it is important to quickly build trust.

- For patients, or families, ask a non-medical question:
  “I know about Mr. Jones’ illness, but I was wondering if you can tell me something more about him as a person, what were his hobbies?”

4. **What does the patient/family know?**

  - Make no assumptions; Determine what the patient/family already knows
    - *What do you understand about your condition?*
    - *What have the doctors told you?*
    - *How do you feel things are going?*

  - **Chronic Illness**: *tell me how things have been going for the past 3-6 months—what changes have you noticed?*
5. Medical Review

- Present medical information succinctly
  - Speak slowly, deliberately, clearly
  - No medical jargon
- Present the big picture

“your cancer is growing, there is no further chemotherapy which can halt the spread of cancer, based on your declining function and weight loss, I believe you are dying”.

6. Silence, Respond to Emotions

- Allow silence, give patient/family time to react and ask questions
- Acknowledge and validate reactions prior to any further discussion.
7. Present Broad Care Options

- There are generally two broad care options:
  - A. Continue aggressive care aimed at restoring function or prolonging life.
  - B. Withdrawal of some or all life-sustaining treatments.

- To help patients and families arrive at a decision, the two most critical pieces of information are:
  - Prognostic estimation
  - The physician’s recommendation

8. Managing Conflicts

- Remember, acceptance of dying is a process; it occurs at different times for different family members.

- Remember, a sudden illness or illness in a young person makes acceptance of dying more difficult for everyone.

- Remember, prior family conflicts, especially concerning alcohol, drugs or abusive relationships, make decisions very hard to achieve.
Common reasons for conflict?

- The Patient/Family
  - Lack of accurate information
  - Guilt/Fear/Anger
  - Grief—Time
  - Lack of trust
  - Cultural/Religious conflict
  - Dysfunctional family system

Other contributing causes

- The physician
  - Inaccurate information
    - Overly optimistic prognosis
  - Guilt-Anger-Fear
    - Fear of malpractice
    - Fear of ethical impropriety
    - Peer pressure (perceived or real)
    - Fear of mistakes
    - Prognostic Uncertainty
  - Cultural conflict between MD values and patient values
9. Translate goals into a plan

- **Ask**
  - *We have discussed that time is short. Knowing that, what is important to you… What do you need/want to do in the time you have left?*

- **Typical responses**
  - Home; Family; Comfort
  - Upcoming life events (e.g., wedding anniversary)

- **Confirm Goals**
  - *So what you are saying is that you want to be home, be free of pain, and would like to live beyond your next wedding anniversary in six weeks, is that correct?*

10. Summarize and Document

- **Summarize areas of consensus and disagreement**
- **Caution against unexpected outcomes**—the dying patient does not always die!
- **Provide continuity**
- **Document in the medical record**
  - Who was present, what was decided, what are the next steps
- **Discuss results w/ health professionals not present**
Summary of Key Steps

1. Pre-meeting planning
2. Proper environment
3. Introductions/Build relationship
4. What does the patient/family know?
5. Medical review
6. Silence, respond to emotions
7. Present options
8. Manage conflict
9. Transform goals into a medical plan
10. Summarize and document

References

Cohen, JJ. Moving from provider-centered toward family-centered care. Academic Medicine, 1999; 74(4) 425.