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Breaking bad news to patient/attendants: A Medical Dilemma

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Abstract: Any information given to the patients or their relatives that drastically changes their mental state or emotions, is considered as a bad news. Breaking bad news properly is an essential skill for all healthcare professionals as the same may be required to be repeated multiple times during their professional careers. This is a negotiation process between the doctor and the patient, but for a diversity of reasons, doctors frequently find it challenging. They are apprehensive of provoking a bad response from the patient or their family members and may feel uncomfortable. For the most part, doctors and other healthcare professionals, inadequate training in delivering unpleasant news is considered as a handicap in their medical practice. Developing this talent requires adherence to the client-centered counselling tenets. In this paper, the authors analyse the forward a six-step SPIKES protocol, as a systematic and easy communication strategy for breaking bad news. Gaining proficiency in handling challenging circumstances offers beneficial therapeutic effects and is a fulfilling career path.

Keywords: Bad News, Communication, SPIKES, Client-centered, Counselling.

Introduction:

Communication is a human capability that can be improved through interaction and training as an essential skill. Establishing effective and good communication reduces stress and increases satisfaction among the recipients of health services. This effective communication helps the patient to be aware of the ailment and treatment options which then help them to make the right decision. One of the most important aspects of communication in the healthcare system is the process of breaking bad news.[1] As a healthcare service provider,

the medical professionals aim to provide the best possible medical healthcare to the patients as per their clinical skills and knowledge. Across different cultures, doctors and health care professionals have been equated to a God-like entity since time immemorial, who provide hope to the despondent patient for a better and healthy future. When a patient approaches a doctor for treatment of his illnesses, he comes with the expectation that he will be cured of his disease and resume a healthy lifestyle soon. However, sometimes the diagnosis or the prognosis of the disease may have antagonistic information which in common terminology may be called a bad news. It is defined as one which is pertaining to a situation where there is a feeling of no hope, a threat to a person's mental or physical well-being, a risk of upsetting an established lifestyle, or where a message is given that conveys to an individual fewer choices in his or her life. In context of The Indian society where the family is still a close-knit unit compared to the West, various family members react differently to an adverse news.[2] Another definition states that "any news that drastically and negatively alters the patient's view of her or his future" is a bad news.[3] Disclosure of any adverse information not only hurts the patient and their relatives but also puts the healthcare worker in an uncomfortable situation. Several empirical studies have documented the physician-patient communication as suboptimal. The main causes for physician's avoidance of the task of breaking bad news may be lack of skills or the hesitancy to deal with the patient's feelings.[4] Breaking bad news is a balancing act that requires clinicians to adapt continually to different factors such as their relationships with the patient, the patient's family, the institutional and systemic environment, and the cultural background.[5] Some literature has shown a significant difference between patient's and physician's preferences on the ways to break bad news. In addition, these studies have indicated that most clinicians found this task a complex communication skill and they had much difficulty telling the truth to their patients, so they strongly felt the need for training on this important issue.[6] Despite the availability of an extensive body of research and online resources, communication lacunae pose hurdles in cultivating good therapeutic relationships. One of the most successful approaches to breaking bad news

is through client-centered counselling, as proposed by Karl Rogers. He put forward three points to achieve a growth-producing therapeutic relationship between the client (the patient) and the counsellor (the physician). They are (1) be genuine and congruent, (2) offer unconditional positive regard, and (3) feel and communicate a deep, empathetic understanding.[7] A patient-centered communication style has the most positive outcome for receivers of bad news on a cognitive, evaluative and emotional level. The physician's attitude and how he conveys the important news is exceptionally pivotal for the patient. A cool, detached posture of true professionalism would be viewed by the patient as well as their relatives as evasive, cold, and unsympathetic at just the time that they are in much need of empathy and support may prove counterproductive.[4] The doctor should not use any blocking behaviors to immunize himself from the potential distress that he may not be able to handle. Some of the blocking behaviors include giving advice and reassurances too soon before addressing the patient's primary concerns, portraying the patient's distress as normal, downplaying the issues, changing the subject of the conversation, and making inappropriate jokes.[8]

What are the barriers to breaking bad news?

Breaking bad news can take a heavy emotional burden on the doctor, he often feels burdened by negative news and anticipates negative reactions. The common barriers faced by doctors for breaking bad news may be enumerated as:[9]

1. The patient's expectations are unknown to the doctor
2. The doctor fears that he might be annihilating the expectation of the patient
3. The doctor may fear that he may not be adequately capable of dealing with any untreatable disease.
4. The doctor may be concerned that he will be unable to control his emotions after telling the patient.
5. The doctor might have presented an overoptimistic picture of the patient's condition in the past and this may be causing embarrassment in the current situation where he needs to break the bad news

The healthcare team should be prepared to deal with a wide range of emotional outbursts when the news of a sudden death comes. Every person's grief response is unique and will be different from one person ranging from initial shock reaction; to denial, proceeding

to anger, guilt and later on acceptance of the condition.[10]

Many protocols have been used in the healthcare system to deliver bad news to patients or patient's relatives, however SPIKES model is most prevalent.

BOX 1:

1. SPIKES PROTOCOL

S- Setting up interview

P- Assessing patient's perception

I- Obtaining the patient invitation

K-Giving knowledge and information to the patient

E- Addressing the patient's emotions with empathetic response

S- Strategy and summary

Well-established SPIKES Protocol described by Walter F. Baile , for disclosing unfavourable information or bad news. Pertaining to clinical practice but we will discuss how we can implement the steps in forensic medicine settings.

Step 1: SETTING UP the interview:
First decide what to say, where to say, whom to say and how to say.
The aim of this is to get the physical context right by maximizing the privacy, avoiding any unnecessary interruptions, to help patients to listen, understand and respect confidentiality.

Step 2: Assessing the patient's PERCEPTION:
Finding out how much the patient knows. The style and emotional content of the patient's statements provide you with information. Terms that are used or avoided and tone of voice will
give information about the patient's level of understanding and whether the implications of the
information have been taken in. It is important to learn the patient's level of understanding and
articulation so that the professional can later begin the information-giving at the same level. In our practice, this is the most important step as more often than not, the relatives of the patient are agitated and are in need of an answer from the investigating agencies are more than eager to direct them towards the doctor for their queries and concerns.

Step 3: Obtaining the patient's INVITATION:
Finding out how much the patient wants to know. In any conversation about bad news the real issue is not "do you want to know?" but "at what level do you want to know?"
A skilful communicator deals sensitively with such situations. In our field, divulging all the
details to near and dear ones may lead to unforeseen

circumstances which may have larger repercussions.

Step 4: Giving KNOWLEDGE and information to the patient:

Giving information to the relatives gradually while observing their reaction and in a language that the recipient may understand. Listen to their concerns and queries and respond accordingly.

Step 5: Addressing the patient's EMOTIONS with empathic responses:

Do not argue. Allow expression of emotion without criticism. Especially important while dealing with agitated crowd and one I feel we as a fraternity need to work on.

Step 6: Strategy and Summary

The aforementioned 6 steps may be developed for clinical practice set-up but as we can see that the core concepts are somewhat similar, however, execution may vary depending upon the set up.[11]

Application of SPIKES protocol for delivering bad news in forensic medicine setting:

Medicine deals with this issue more frequently than we assume, however, a major difference is that the news we provide by a forensic medicine expert are often different than the breaking bad news to cancer or chronically ill patients. More often the bad news is delivered to the near and dear ones of the deceased which is not always the case in clinical specialties where the patient may himself/herself may be the first one to receive the news. Rarely, examination of survivors of some form of sexual abuse presents an opportunity where we may have to deal with the person concerned directly. Citing a few examples from our own experiences where the autopsy surgeon may be the bearer of bad news:

- Parents discovering about unknown pregnancy in their child during autopsy.
- Breaking news of sexual assault of the deceased based upon the findings of post mortem examination.
- Dowry deaths.
- Deaths involving drugs and alcohol
- Sudden death of a young person, presumed healthy.
- Custodial deaths and deaths due to police action such as encounter etc.
- Cases where claims of compensation have been made.

Conclusion:

The act of kindness by healthcare professionals shown during the hour of need will help to strengthen the doctor-patient relationship further. The family will undoubtedly value the commitment of the healthcare team regardless of the outcome. In view of improving the skills of the professional, there should be conduction of workshops, viewing videotaped interactions between clinicians and simulated bereaved relatives, and small group role-plays could be efficient methods to teach clinicians how to break bad news

in the stressful environment of an emergency room.

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