Learning Objectives
After reading this section, participants will be able to:
1. Be able to define bad news and what makes it bad
2. Identify barriers to giving bad news to patients and family
3. Be able to list and explain the 6 steps for giving bad news.

Why This Topic?
Bad news can be defined as any information which adversely alters one’s expectations for the future. Oncologists give bad news thousands of times during the course of a career. This stressful task is made more difficult when the clinician has a longstanding relationship with the patient, when the patient is young, or when strong optimism had been expressed for a successful outcome. Very few clinicians have been formally, or even informally, trained in giving bad news. Therefore, some use communication techniques which undermine patient trust and satisfaction. These include giving the bad news bluntly in a detached and mechanistic manner, creating false hopes through use of excessive optimism, withholding adverse information, such as a poor prognosis from the patient, and giving the family information but not the patient.

When bad news is communicated in an empathic manner, it can have an important impact on outcomes such as patient satisfaction and decreased patient anxiety and depression. However, there are significant challenges to giving bad news, including:
- giving information consistent with the patient’s prior understanding of the disease,
- discussing bad news while supporting patient hopes for a good outcome,
- addressing emotional reactions, such as crying and anger, and
- encouraging patient participation in decision-making.

Recommended Procedure
As with any medical procedure, giving bad news requires a coherent strategy in order for it to be accomplished successfully. In this case the strategy encompasses a series of six distinct communication steps, that can be summarized using the mnemonic SPIKES.
S = SETUP. Set up the situation so it has a good chance of going smoothly. Before you go into the room have a plan in your mind. Ask yourself how difficult it will be to have the discussion. Difficult discussions might go better if you talk to someone ahead of time or have a nurse or social worker accompany you. Turn your pager off or give it to someone else so you are not interrupted. Sit down, make eye contact, and get reasonably close to the patient. Anticipate that the patient will be upset and have some tissues ready.

P = PERCEPTION. Find out the patient’s perception of the medical situation. What has he been told about the disease? What does he know about the purpose of the unfavorable test results you are about to discuss? If this is a first contact, what has he been told about why he should see you in referral? What are his expectations of treatment? What are his goals? Correct any misconceptions or misunderstandings the patient may have. Note any strong denial or its mimics (e.g., avoidance of topics or excessive optimism).

I = INVITATION. Find out how much information the patient wants. These days most patients want a lot of information but this is not universally true, especially as the disease progresses and patients may want to focus on “What do we do next?”

K = KNOWLEDGE. Use language that matches the patient’s level of education. Be direct. Avoid using jargon as it will confuse the patient. Give a warning that bad news is coming: “I have some serious news to tell you.” This will allow the patient to prepare psychologically. If the patient’s perception (step 2) was inaccurate, review pertinent information: “Now you remember we sent you for the MRI to assess how the chemo was working? Well, what we found is that the chemo has not worked. The tumor has grown larger.” After giving this news, stay quiet for at least 10-15 seconds-resist the urge to tell the patient how to feel. Give the patient time to absorb the information and respond.

E = EMPATHIZE. Use empathic statements to respond to patient emotions. This will assist in patient recovery and dampen the psychological isolation which the patient experiences when they hear the bad news. If a patient begins to cry, wait until he is ready to talk; then remember NURSE (see Module #1), and use an empathic response such as “This must be disappointing for you.” Resist the temptation to make things better, for example rushing to propose a treatment which is unlikely to work. This kind of response can be a reaction to your own sense of helplessness and perhaps of failure. Ask if the patient has questions or concerns and keep asking until he says “no.”

S = SUMMARIZE AND STRATEGIZE. Summarize the clinical information and make a plan for the next step, which may be further testing or discussion of treatment options (see Module #3). Be as concrete as possible and check on the patient’s understanding of what has been discussed: “Does this make sense to you?” or “Are you clear about the next steps?”

Pearls/Ideas to Facilitate Giving Bad News

- Eliciting the patient’s concerns can help the patient feel heard and help you plan. “What concerns you most about this news?” These concerns may range far beyond the medical decisions at hand and may represent important concerns and barriers to treatment, e.g., “Who will take care of my children while I have the treatments?”
- When patients ask difficult questions such as “How long do I have to live?” asking about their affect first will give you a sense of why they are asking the question. Reassure them that you will provide the information about prognosis so they don’t think you’re being evasive. For example, you might say, “I will answer your question, but first let me ask, I wonder if it’s scary not knowing what to expect in the future?”
- Allow patients to audiotape the conversation about the treatment plan. Either have a tape recorder available for them to use or let them know ahead of time so they can bring one. This can be very helpful, although one study indicated that in the setting of cancer relapse, this increased patient anxiety.
- Be aware of your own emotions such as sadness, guilt, disappointment or shame. Discuss these with colleagues prior to the visit to decrease the likelihood they will interfere with your encounter with the patient.
- Try and accept the fact that being empathic, interested, and affirming are powerful verbal techniques that the patients recognize as demonstrations of your support.
- You can help your patients hope for the best while also preparing them for the worst. Acknowledging that these two apparently conflicting emotions can co-exist gives you the opportunity to explore hopes and concerns and signals that you are willing to discuss both.
Pitfalls/Common Barriers to Good Communication

- Feeling you are responsible for maintaining the patient’s hope
- Ignoring your own feelings
- Making assumptions about what the patient knows and doesn’t know
- Assuming that cure is the goal of all patients
- Talking too much

REFERENCES

Included in this notebook

Additional references (not included)