Giving Bad News

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In the practice of oncology, it is difficult not to be impressed by the number of clinical situations that necessitate the conveyance of unfavorable medical information to patients and families. These include the communication of the cancer diagnosis, a poor prognosis, the failure of anticancer treatment, the occurrence of unwanted and significant side effects, the ineligibility for a clinical trial, sudden and unexpected death, the discussion of hospice, and, more recently, a focus on the disclosure of medical errors. The estimate that these “bad news” discussions can occur more than 20,000 times during the course of an oncologist’s career [1, 2] underscores the importance of this communication competency for patient care.

SPIKES (setting, perception, invitation for information, knowledge, empathy, summarize and strategize) is a skills-based, best-practices approach to giving bad news. Although not formally tested in a clinical trial, the communication skills it proposes, or similar ones, have been found to positively affect patient outcomes in one or more studies [3]. Its steps have been incorporated into guidelines for clinician-patient communication [4, 5] and for error disclosure [6] and have also been used in programs for teaching the communication of bad news to oncologists, medical oncology fellows, and others [7, 8].

Although the SPIKES protocol has been adapted to many important “bad news” discussions, Morgans and Schapira in their report in this issue of *The Oncologist* address the use of SPIKES in the context of discussing treatment failure in an era of ever-expanding treatment options. They are quite correct in pointing out that this is a particularly “high-stakes” conversation for the patient and loved ones and is often a daunting task for the clinician. In the original report in which we introduced the SPIKES protocol [2], we cited data from a survey of 500 oncologists, almost one half of whom thought that talking about the end of anticancer treatment [9, 10]. This latter point was highlighted in a study by Wallace et al. [11], presented at the annual meeting of the American Society for Clinical Oncology in 2006. They polled more than 1,000 medical oncologists about their experiences in giving bad news about a poor prognosis (disease progression and death likely in the next 6–12 months) to patients with advanced cancer. Among the 729 oncologists who responded, nearly 50% admitted to having strong negative feelings, such as sadness, pain, guilt, heartbreak, and stress. These feelings, repeated over and over again in the work of caring for very ill patients, are surely a recipe for burnout.

Recognizing this, Morgan and Schapira discussed several techniques for mitigating the stress associated with discussing bad news. These can include reviewing what the patient already has been told about the prospects of a previous treatment, anticipating an emotional reaction, and rehearsing steps, such as being calm and empathic, for dealing with patient emotions.

Other investigators have made additional and important refinements to SPIKES, such as addressing cultural factors [12], setting goals of care and checking on what information the patient has actually absorbed and understood [13], and using decision-making tools to help ensure treatment decisions are more patient-centered [14].

Another important aspect of stress management is the creation of mindfulness about one’s own emotional reactions and unhelpful attitudes around giving bad news, such as the fear of being blamed, fear of unleashing an emotional reaction in the patient’s family, expressing one’s own emotion, and taking responsibility for the bad news itself [15]. These reactions can drive a wedge in the doctor-patient relationship if the result is the clinician's distancing himself or herself from the patient or attempting to shield the patient from distress. The consequences can be misunderstanding by the patient and family about the purpose of care and/or the loss of honest and supportive communication at a time when the patient needs the doctor the most [16–20].

Being mindful is a way of being aware in the moment of our own feelings through nonjudgmental observation so we can act on them with calmness and wisdom [21]. This can be important for clinicians who are particularly sensitive to the stress of giving bad news [10] or who tend to judge themselves too severly. These clinicians might benefit from emotional self-management strategies such as those described in the reports by Krasner et al. [22] and McCrty et al. [23].
When delivering bad news, oncologists must also be prepared to react appropriately to strong patient and family reactions, including their sadness, anger, disbelief, and/or denial [24]. In previous correspondence, we pointed out how patients’ emotions can cause the bearer of bad news to flounder because the patient reactions in themselves can elicit additional anxiety [25]. This psychological dynamic has been called “amygdala hijacking” by Goleman [26], who explains how reacting to others with our “emotional brain” can bring unintended consequences. These have been illustrated by Finset et al. [27], who found that oncologists often responded to negative emotions in cancer patients by changing the topic, asking a question, providing factual information, or reassuring the patient, instead of responding with an empathic phrase, such as described by Morgan and Schapira. Buckman [28] recommends a strategy termed “separating the messenger from the message,” which helps oncologists to not assume responsibility for the bad news or the patient’s emotional reaction to it, but instead to refocus attention on the message itself and the support that the oncologist can provide to the patient.

Communication skills training programs can provide awareness of emotions and the opportunity to practice giving bad news. In our workshops for oncology clinicians on end-of-life discussions [29], we use advanced role-playing techniques to encourage participants to recognize the range of both the clinician’s and the patient’s feelings, and their consequences, in bad news discussions. Taking on the role of a patient or family member in receiving bad news can help guide clinician communication by providing insight into the question, “What does this patient and family need from me?” By putting oneself in the shoes of the patient, it can become apparent that false reassurance or avoidance might not be the most effective strategy and that the patient might benefit more from honesty and support [30].

From the above, we can agree, as Bousquet et al. have pointed out [31] and as Morgan and Schapira have illustrated, that in giving bad news, SPIKES is best viewed as a flexible guideline to help the physician address individual patient and family needs in a personalized and “patient-centered” manner.

REFERENCES


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EDITOR’S NOTE: See the related article, “Confronting Therapeutic Failure: A Conversation Guide,” on page 946 of this issue.