Breaking bad news

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As psychiatrists, we do not often encounter situations in which we need to inform patients and their families that they have a life-threatening diagnosis. Nonetheless, on the rare occasions when we work with such patients, new psychiatrists may find their clinical skills challenged. Breaking bad news remains an aspect of clinical training that is often overlooked by medical schools.

Here I present a case that illustrates the challenges residents and medical students face when they need to deliver bad news and review the current literature on how to present patients with this type of information.

CASE

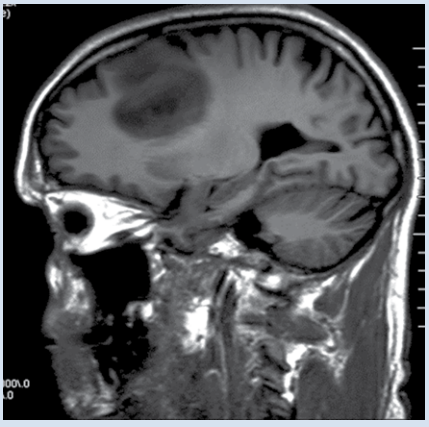
Bizarre behavior, difficult diagnosis

Mr. C, age 59, with a 1-year history of major depressive disorder, was brought to the emergency department by his wife for worsening depression and disorganized behavior over the course of 3 weeks. Mr. C had obsessive thoughts about arranging things in symmetrical patterns, difficulty sleeping, loss of appetite, and anhedonia. His wife reported that his bizarre, disorganized behavior further intensified in the previous week; he was urinating on the rug, rubbing his genitals against the bathroom counter, staring into space without moving for prolonged periods of time, and arranging his food in symmetrical patterns. Mr. C has no reported substance use or suicidal or homicidal ideation.

Mr. C's age (ie, >40 years) and new-onset psychiatric and neurologic symptoms were concerning for an underlying neurologic etiology and warranted neuroimaging. A CT scan of the head demonstrated a mass, 5.3 × 6.8 cm anteroposterior, in the frontal lobe around the corpus callosum, accompanied by edema and mass effect (***Figure***). Mr. C was transferred to neurosurgery, where a brain biopsy demonstrated high-grade glioblastoma multiforme that required surgical intervention.[1]

Figure

Patient's head CT scan showing a frontal mass with edema and mass effect



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LET YOUR VOICE BE HEARD

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The author reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

Table 1

6-Step SPIKES model

1. Set up the interview
- Rehearse mentally; review the plan for telling the patient and how to respond to his (her) emotional reactions or difficult questions
- Arrange for some privacy
- Involve significant others, if that is the patient's choice
- Sit down with the patient
- Make a connection with the patient: maintain eye contact and/or touch the patient on the arm or hold a hand if he (she) is comfortable with you doing so
- Manage time constraints and interruptions; set your pager on silent or ask a colleague to respond to your pages

2. Assess the patient's perception
- Determine what the patient knows about the medical condition or what he (she) suspects
- Listen to the patient's level of comprehension
- Determine if the patient is engaging in illness denial

3. Obtain the patient's invitation
- Ask the patient if he (she) wishes to know the details of the medical condition and/or treatment
- Accept the patient's right not to know
- Offer to answer questions later if he (she) wishes

4. Give knowledge and information
- Warn the patient that bad news is coming; this may lessen the shock that can follow the disclosure of bad news
- Start at the patient's level of comprehension and vocabulary
- Use non-technical words
- Avoid excessive bluntness
- Give information in small chunks, and periodically check the patient's understanding
- Avoid using phrases such as "There is nothing more we can do for you"; this attitude is inconsistent with the fact that patients often have other important therapeutic goals

5. Address the patient's emotions with empathic responses
- Observe for any emotion on the part of the patient
- Identify the emotion experienced by the patient by naming it to oneself
- Identify the reason for the emotion
- Let the patient know you have connected the emotion with the reason for the emotion by making a connecting statement

6. Strategize and summarize
- Close the interview
- Ask the patient whether he (she) wants to clarify something else
- Offer an agenda for the next meeting

Source: Reference 2

Clinical Point

Delivering bad news with empathy and being involved in the struggle that follows can make a significant difference

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Strategies for delivering bad news

Initially, I struggled when I realized I would have to deliver the news of this potentially life-threatening diagnosis to the patient and his wife because I had not received any training on how to do so. However, I took time to look into the literature and used the skills that we as psychiatrists have, including empathy, listening, and validation. My experience with Mr. C and his family made me realize that delivering bad news with empathy and being involved in the struggle that follows can make a significant difference to their suffering.

There are various models and techniques for breaking bad news to patients. Two of the most commonly used models in the oncology setting are the SPIKES (**S**et up, **P**erception, **I**nterview, **K**nowledge, **E**motions, **S**trategize

and **S**ummarize) model (***Table 1***,[2] ***page e2***) and Kaye's model (***Table 2***[3]).

A clinician's attitude and communication skills play a crucial role in how well patients and family members cope when they receive bad news. When delivering bad news:

- Choose a setting with adequate privacy, use simple language that distills medical facts into appreciable pieces of information, and give the recipients ample space and time to process the implications. Doing so will foster better understanding and facilitate their acceptance of the bad news.
- Although physicians can rarely appreciate the patient's feelings at a personal level, make every effort to validate their thoughts and offer emotional support. In such situations, it is often appropriate to move closer to the recipient and make brief physical gestures, such as laying a hand on the shoulder, which might comfort them.
- In the aftermath of such encounters, it is important to remain active in the patient's emotional journey and available for further clarification, which can mitigate uncertainties and facilitate the difficult process of coming to terms with new realities.[4,5]

References

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Table 2

Kaye's model

1. Prepare
- Know all the facts
- Ensure privacy
- Find out who the patient would like present
- Introduce yourself

2. Determine what the patient knows
- Start with open-ended questions (eg,"How did it all start?")

3. Determine if more information is wanted
- Do not force information on to the patient (eg, "Would you like me to explain a bit more?")

4. Give warning shots
- Not straight out with it! (ie, "I'm afraid it looks rather serious")

5. Allow denial
- Denial is a defense mechanism and a way of coping
- Allow the patient to control the amount of information he (she) receives

6. Explain if requested
- Go step by step
- Details might not be remembered, but the way you explain them will be

7. Listen to concerns
- Ask "What are your concerns at the moment?"
- Allow time and space for answers

8. Encourage feelings
- Acknowledge the feelings
- Be nonjudgmental

9. Summarize
- Review concerns, plans for treatment
- Foster hope
- Offer written information if asked

10. Follow up
- Offer further information
- Assure patient of your continued availability

Source: Reference 3

Clinical Point

Your attitude and communication skills play a crucial role in how well patients and family members cope with bad news