GIVING PATIENTS BAD NEWS

The Six Steps of SPIKES (WF Baile et al.)

STEP 1: S—SETTING UP the Interview

Mental rehearsal is a useful way for preparing for stressful tasks. This can be accomplished by reviewing the plan for telling the patient and how one will respond to patients' emotional reactions or difficult questions. As the messenger of bad news, one should expect to have negative feelings and to feel frustration or responsibility [55]. It is helpful to be reminded that, although bad news may be very sad for the patients, the information may be important in allowing them to plan for the future.

Sometimes the physical setting causes interviews about sensitive topics to flounder. Unless there is a semblance of privacy and the setting is conducive to undistracted and focused discussion, the goals of the interview may not be met. Some helpful guidelines

•Arrange for some privacy. An interview room is ideal, but, if one is not available, draw the curtains around the patient's bed. Have tissues ready in case the patient becomes upset.

•Involve significant others. Most patients want to have someone else with them but this should be the patient's choice. When there are many family members, ask the patient to choose one or two family representatives.

•Sit down. Sitting down relaxes the patient and is also a sign that you will not rush. When you sit, try not to have barriers between you and the patient. If you have recently examined the patient, allow them to dress before the discussion.

•Make connection with the patient. Maintaining eye contact may be uncomfortable but it is an important way of establishing rapport. Touching the patient on the arm or holding a hand (if the patient is comfortable with this) is another way to accomplish this.

•Manage time constraints and interruptions. Inform the patient of any time constraints you may have or interruptions you expect. Set your pager on silent or ask a colleague to respond to your pages.

STEP 2: P—Assessing the Patient's PERCEPTION

Steps 2 and 3 of SPIKES are points in the interview where you implement the axiom “before you tell, ask.” That is, before discussing the medical findings, the clinician uses open-ended questions to create a reasonably accurate picture of how the patient perceives the medical situation—what it is and whether it is serious or not. For example, “What have you been told about your medical situation so far?” or “What is your understanding of the reasons we did the MRI?”. Based on this information you can correct misinformation and tailor the bad news to what the patient understands. It can also accomplish the important task of determining if the patient is engaging in any variation of illness denial: wishful thinking, omission of essential but unfavorable medical details of the illness, or unrealistic expectations of treatment [56].

STEP 3: I—Obtaining the Patient's INVITATION

While a majority of patients express a desire for full information about their diagnosis, prognosis, and details of their illness, some patients do not. When a clinician hears a patient express explicitly a desire for information, it may lessen the anxiety associated with divulging the bad

news [57]. However, shunning information is a valid psychological coping mechanism [58, 59] and may be more likely to be manifested as the illness becomes more severe [60]. Discussing information disclosure at the time of ordering tests can cue the physician to plan the next discussion with the patient. Examples of questions asked the patient would be, “How would you like me to give the information about the test results? Would you like me to give you all the information or sketch out the results and spend more time discussing the treatment plan?”. If patients do not want to know details, offer to answer any questions they may have in the future or to talk to a relative or friend.

STEP 4: K—Giving KNOWLEDGE and Information to the Patient

Warning the patient that bad news is coming may lessen the shock that can follow the disclosure of bad news [32] and may facilitate information processing [61]. Examples of phrases that can be used include, “Unfortunately I've got some bad news to tell you” or “I'm sorry to tell you that…”.

Giving medical facts, the one-way part of the physician-patient dialogue, may be improved by a few simple guidelines. First, start at the level of comprehension and vocabulary of the patient. Second, try to use nontechnical words such as “spread” instead of “metastasized” and “sample of tissue” instead of “biopsy.” Third, avoid excessive bluntness (e.g., “You have very bad cancer and unless you get treatment immediately you are going to die.”) as it is likely to leave the patient isolated and later angry, with a tendency to blame the messenger of the bad news [4, 32, 61]. Fourth, give information in small chunks and check periodically as to the patient's understanding. Fifth, when the prognosis is poor, 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 such as good pain control and symptom relief [35, 62].

STEP 5: E—Addressing the Patient's EMOTIONS with Empathic Responses

Responding to the patient's emotions is one of the most difficult challenges of breaking bad news [3, 13]. Patients' emotional reactions may vary from silence to disbelief, crying, denial, or anger.

When patients get bad news their emotional reaction is often an expression of shock, isolation, and grief. In this situation the physician can offer support and solidarity to the patient by making an empathic response. An empathic response consists of four steps [3]:

- First, observe for any emotion on the part of the patient. This may be tearfulness, a look of sadness, silence, or shock.
- Second, identify the emotion experienced by the patient by naming it to oneself. If a patient appears sad but is silent, use open questions to query the patient as to what they are thinking or feeling.
- Third, identify the reason for the emotion. This is usually connected to the bad news. However, if you are not sure, again, ask the patient.
- Fourth, after you have given the patient a brief period of time to express his or her feelings, let the patient know that you have connected the emotion with the reason for the emotion by making a connecting statement

STEP 6: S—STRATEGY and SUMMARY

Patients who have a clear plan for the future are less likely to feel anxious and uncertain. Before discussing a treatment plan, it is important to ask patients if they are ready at that time for such a discussion. Presenting treatment options to patients when they are available is not only a legal mandate in some cases [68], but it will establish the perception that the physician regards their wishes as important. Sharing responsibility for decision-making with the patient may also reduce any sense of failure on the part of the physician when treatment is not successful. Checking the patient's misunderstanding of the discussion can prevent the documented tendency of patients to overestimate the efficacy or misunderstand the purpose of treatment [7-9, 57].

Clinicians are often very uncomfortable when they must discuss prognosis and treatment options with the patient, if the information is unfavorable. Based on our own observations and those of others [1, 5, 6, 10, 44-46], we believe that the discomfort is based on a number of concerns that physicians experience. These include uncertainty about the patient's expectations, fear of destroying the patient's hope, fear of their own inadequacy in the face of uncontrollable disease, not feeling prepared to manage the patient's anticipated emotional reactions, and sometimes embarrassment at having previously painted too optimistic a picture for the patient.

These difficult discussions can be greatly facilitated by using several strategies. First, many patients already have some idea of the seriousness of their illness and of the limitations of treatment but are afraid to bring it up or ask about outcomes. Exploring the patient's knowledge, expectations, and hopes (step 2 of SPIKES) will allow the physician to understand where the patient is and to start the discussion from that point. When patients have unrealistic expectations (e.g., “They told me that you work miracles.”), asking the patient to describe the history of the illness will usually reveal fears, concerns, and emotions that lie behind the expectation. Patients may see cure as a global solution to several different problems that are significant for them. These may include loss of a job, inability to care for the family, pain and suffering, hardship on others, or impaired mobility. Expressing these fears and concerns will often allow the patient to acknowledge the seriousness of their condition. If patients become emotionally upset in discussing their concerns, it would be appropriate to use the strategies outlined in step 5 of SPIKES. Second, understanding the important specific goals that many patients have, such as symptom control, and making sure that they receive the best possible treatment and continuity of care will allow the physician to frame hope in terms of what it is possible to accomplish. This can be very reassuring to patients.

Quoted from Baile WF, et al. SPIKES- A Six Step Protocol for Delivering Bad News: Application to the Patient with Cancer. The Oncologist 2000; vol 5; pp 302-311.