

Breaking Bad News

Communication Session

May 11, 2017

CLRC – 1-3pm

Pre-Read

1. Buckman RA – *Commun Oncol* – 2005
2. CMPA Information: <https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2005/disclosing-adverse-events-to-patients-strengthening-the-doctor-patient-relationship>

Objectives:

Large group session

1. To discuss – as a collection of residents and staff – general principles and strategies to employ when delivering bad news to a patient and/or family
2. To share examples of breaking bad news from one's own experience(s) and to share positive/successful and negative/unsuccessful aspects of those experience(s)

Breakout group session

1. To develop tools – including active and passive listening, cultural appreciation, use of terms and jargon, and summarization – that will serve as a basis for future situations of breaking bad news to a patient and/or family.
2. As an active, involved participant, to engage in a scenario of breaking bad news to a patient/family and be receptive to feedback from peers and staff regarding that interaction.
3. As an active, observing participant, to identify strengths and areas for improvement in peers engaging in clinical scenarios of breaking bad news.

Strategies/Principles:

What is Bad News?

- It's relative
- Think of it as “the gap that exists between the patient's expectations of the situation and the medical reality of it” AND “the inability for you to know how one might take the information until you gain appreciation of their understanding”
- Example
 - o Child born with Down Syndrome
 - Parents may recognize features or have had some pre-existing concern (i.e. from prenatal testing) and thus sharing the news may not be as challenging as compared to another family caught blindsided
 - o New onset diabetes
 - Parents of no children with diabetes vs parents bringing in a sibling already having recognized the symptoms and checked a blood sugar

Why is Breaking Bad News Hard

- Witnessing other's distress
- Personal experiences of past cases
- Lack of experience in breaking bad news
- Feeling helpless or guilty
- Time constraints
- Lack of clinical understanding
- Lack of adequate debriefing for health care professionals

- Residents
 - o Covering call
 - o Experience
 - o Fatigue

Why is It Needed

- Ethical and legal obligation
- Most patients want to know (95%) though some don't

SPIKES

Setting: privacy, involve significant others, sitting down, look attentive and calm, listening, being available (limited interruptions)

Perception: asking the patient what they know, understand, have been told thus far

Invitation: asking if they want to know → “would you like for me to discuss in detail about what is going on or would you prefer that I just tell you about the treatment(s) I can offer?”

How this applies in pediatrics

Knowledge: give you patient a warning (“unfortunately, I have to tell you...”); avoid too much jargon and use their terms when able; give info in chunks, tailor the rate of information given to the patient's understanding

Empathy: listen for emotion, identify where the emotion may be coming from; try to link emotion and the information from which that emotion may be driven

Summary and strategy: ensure information heard; recap; provide a plan

Other things:

- know who everyone is and their names when able
- involve the child/adolescent as much as able and where appropriate
- include another HCP when relevant (i.e bedside nurse or other)
- allow silence – it is hard
- offer to return to review again

- where appropriate, touch (hand on knee, hug, etc) can be appropriate
- be patient, especially with those becoming upset/crying
- it's okay to say you don't know certain things, etc.
- cultural differences
- debrief

Examples:

1) Talking to parents about doing a brain death protocol in a 2 year old severe head trauma patient (including organ donation)

Child in a recent MVA → brain death declared 48 hours later

Both parents present

As the attending, you must discuss with them the results of the testing to confirm brain death; you also want to discuss organ donation prior to withdrawing complete life support.

2) A 10 month old is in hospital comatose following a viral infection. Their MRI looks suggestive of Cree Leukodystrophy. This is a fatal and nontreatable condition with most children dying within a few weeks to months. Genetic testing is needed to confirm the diagnosis.

3) A 3 year old child presents with new onset irritability and gait ataxia. An urgent MRI confirms a posterior fossa tumour.

Both parents present

No expectations – assume child has some type of illness causing symptoms that will resolve

4) Other examples.....