Breaking bad news: the S-P-I-K-E-S strategy

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Breaking bad news to patients is one of the most difficult and demanding tasks that oncologists face—and one for which they are often poorly trained and emotionally ill equipped. The S-P-I-K-E-S protocol described in this article provides a simple, easily learned strategy for communicating bad news and suggests ways to assess the situation as it evolves and respond constructively to patients. Showing empathy, exploring the patient's understanding and acceptance of what he or she has just learned, and validating that patient's feelings can provide much-needed support to the patient, an essential psychological intervention for managing distress and helping the patient face the treatment decisions ahead. Although breaking bad news will never be easy, having a plan of action and knowing that you can support your patient through a difficult period should help considerably.

In every area of clinical oncology practice, it is always difficult and awkward to break bad news to a patient, whether at the time of diagnosis, recurrence, disease progression, or transition to palliative therapy. In any circumstance, it is a difficult and demanding task. One recent study showed that 42% of physicians experience stress after breaking bad news, and the effect lasts from several hours to more than 3 days.[1] This article reviews some of the background literature and sets out one practical approach, the S-P-I-K-E-S protocol,[2,3] a strategy now taught and used widely at workshops and available on both CD-ROM disks and videotape.[4] To many readers of *Community Oncology,* the approach that is set out below may make intuitive sense and may reflect what you have been doing in your own practice anyway. Even if that is the case, this overview may be of some value by reinforcing your own clinical practice and by providing you with a teaching tool for your juniors.

Defining 'bad news'

It is important to define the central element of bad news—that is, to try to identify what makes it so bad for the patient. Basically, the impact of bad news is proportional to its effect in changing the patient's expectations. In fact, one practical definition of bad news is "any news that adversely and seriously affects an individual's view of his or her future."[5] All bad news, therefore, has serious adverse consequences for patients and families.[6,7] In turn, this leads to two important guiding principles.

First, the "badness" of the news—in other words, the impact on the patient and family—can be thought of as the gap between the patient's expectations of the situation and the medical reality of it. Second, it follows that, as a clinician, you cannot know how patients will react to bad news until you ascertain their perceptions of their clinical situations. Hence, a valuable rule is "Before you tell, ask."

The need for a strategy

In 1998, at the annual meeting of the American Society of Clinical Oncology, approximately 400 oncologists attended a session on breaking bad news. The oncologists were polled about various aspects of communication skills and training.[3] Less than 5% of those present stated that they had received any training in breaking bad news. More than 66% indicated that they had to break bad news between 5 and 20 times a month; 74% indicated they did not have a specific approach planned for breaking bad news. More than 90% felt that the most difficult aspect of the communication was handling the emotions that arise during the interview. When the S-P-I-K-E-S strategy, which is centered on addressing and acknowledging emotions, was pre-

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sented, more than 99% of the oncologists found it easy to understand and remember. S-P-I-K-E-S is described in detail later in this article.

Why is breaking bad news so difficult?

Simply being present when another person is in great distress can make breaking bad news difficult. There are other reasons. A recent study in Canada explored residents' perceptions about delivering bad news. It showed that the lack of emotional support from other health professionals, their own personal fears about the process, and the amount of time they had available to deliver bad news kept them from being effective in their roles.[8] Some of the weakest areas in the process of delivering bad news are in exploring patients' reactions, imparting the information at the patients' pace, and providing written materials.[9]

Physicians bearing bad news can feel helpless, especially when there are no active treatment options available to the patient.[5] In certain circumstances, you may even feel guilty (usually inappropriately!). Sometimes your own sense of morality looms. So it's not surprising that physicians may find themselves camouflaging the whole truth from the patient in an effort to avoid either the patient's or their own emotional reactions to the bad news.[10,11]

Truth-telling, then and now

Fifty years ago, most physicians were able to avoid discomfort by concealing the truth from patients, justifying this with the claim that the truth would be too distressing for the patients. In his famous survey of 1961, Oken showed that 90% of surgeons in the US did not routinely discuss a cancer diagnosis with their patients, even though it was determined that patients really wanted to hear the diagnosis.[12]

Nearly 20 years later, Novack and colleagues repeated the Oken survey and showed that the position was reversed: By the late 1970s, 90% of physicians told patients if they had cancer.[13] Since then, this has become the norm. We now have legal and ethical obligations to tell our patients any detail about their illness, if that is their wish. Although most of our patients (in excess of 95%, according to the most recent papers) want full disclosure of their medical situation, some would rather not hear it or cannot cope with it. This option is built into the S-P-I-K-E-S protocol.

As has had been said many times, the manner in which you tell the truth may be even more important than the fine details of the information. Insensitive truth-telling can be just as harmful as insensitive concealment. This is where having a strategy for breaking bad news can help you.

The physician's perspective

Over the course of a 40-year career, an oncologist may conduct up to 200,000 interviews with patients, caregivers, and/or families.[14] If as few as 10% of those interviews involve disclosing bad news, that is still 20,000 interviews in which the physician has to be the bearer of bad news.

Because this specialized skill is not taught in most medical schools, physicians typically learn to communicate bad news to patients through professional experience and by watching senior physicians.[15] (Some schools do have well-established courses in the specific techniques of breaking bad news.[16]) At first, it might seem satisfactory to acquire the skills simply by watching senior practitioners. But, in fact, this turns out not to be the case.

Results from a study published by Fallowfield et al in February 2002 indicate that the communication problems of senior oncologists are not resolved with clinical experience.[14] This particular study suggests that training courses significantly improve communication skills. The British government is planning to use Fallowfield's study as a basis for creating a national training program for doctors caring for cancer patients. To date, similar plans are only in the preliminary planning stages in North America. It has also been shown that the skill of communicating bad news to patients can be transferred across specialties, suggesting that time spent learning this skill could have far-reaching benefits in the medical profession.[15]

Meeting patients' expectations

The manner in which bad news is imparted certainly affects patients' lives, but it can also affect patient-physician relationships. Most patients expect full disclosure delivered with empathy, kindness, and clarity.[16] In fact, several studies show that *how* bad news is disclosed can affect patient satisfaction with the care they receive and their subsequent psychological adjustment to bad news.[17,18] For example, a study in 2001 confirmed that patients with higher education expected more details and greater message facilitation regarding their illness and that female patients expected more support.[19]

The S-P-I-K-E-S protocol

The S-P-I-K-E-S protocol is a strategy and not a script. It highlights the most important features of a bad news interview and suggests methods of assessing the situation as it evolves and responding constructively to what happens.

Setting (S)

Privacy. Where the bad news is broken can have significant effects on the outcome of the interview, especially if the setting is inappropriate for a sensitive, private, and potentially devastating discussion. It really is worthwhile trying to find a private location, such as an interview room, your office with the door closed, or curtains drawn around a hospital bed. Ask the patient's permission to turn

off the TV or radio, and try to minimize other distractions.

Involve significant others. Some patients like to have family members or friends with them when they receive bad news. If there are a number of people closely supporting the patient, ask your patient who will act as the spokesperson for the family during the discussion. This gives your patient support while alleviating some of the stress you will experience when dealing with multiple people during an emotionally charged interview.

Sit down. If you have just examined your patient, allow him or her to dress before you begin your discussion. You should be seated during an interview involving bad news, and it is also worth trying to avoid sitting behind physical barriers, such as a desk. If your patient is in a hospital bed, pull up a chair, or if there isn't a chair, ask permission to sit on the edge of the bed. Being seated lessens the intimidating visual impact of the doctor towering over the patient, which can make the patient feel vulnerable. When you sit down, you give the patient a feeling of some form of partnership in the discussion. It's also easier to achieve level eye contact in the seated position.

Look attentive and calm. Most of us feel anxious during a "bad news" interview, and it is worth spending some effort to try to reduce or eliminate the body signals that we tend to send when we are nervous. If, for example, you have a tendency to fidget during tense discussions, you can adopt the "psychotherapy neutral position." This is a simple matter of placing your feet flat on the floor and your ankles together, and putting your hands, palms downward, on your lap. Maintaining eye contact will also assure your patient of your attentiveness; if he or she becomes tearful, it is a good idea to break eye contact momentarily. (No one likes to be seen crying, because he or she feels particularly vulnerable.) You can also rest your hand on your patient's arm or hand if he or she is comfortable with this gesture.

Listening mode. Silence and repetition are two communication skills that will send the message to your patient that you are listening. Your silence (that is, not interrupting or overlapping the patient when he or she is talking) displays respect for what he or she is saying and indicates that you are in a "listening mode." Repetition involves using the most important word from the patient's last sentence in your first sentence. For example, a patient might say, "I'm fed up with the treatment." You might reply, "What aspect of it makes you most fed up?" Other basic techniques that show you are listening include nodding, smiling, or saying "hmmm," as appropriate.

Availability. Before your important discussion, make arrangements for the phones to be answered by other staff members or voice mail and make sure that staff members do not interrupt the meeting. If phone calls or other interruptions do occur, courteously address them so that your patient doesn't feel less important than the interruption. If you have appointments to keep, give your patient a clear indication of your time restraints.

Perception (P)

This step is the center of the "before you tell, ask" principle. Before you break bad news to your patients, you should glean a fairly accurate picture of their perception of the medical situation—in particular, how they view the seriousness of the condition. The exact words you decide to use depend on your own style. Here are a few examples:

"What did you think was going on with you when you felt the lump?"

"What have you been told about all this so far?"

"Are you worried that this might be something serious?"

As your patient responds to your question, take note of the language and vocabulary that he or she is using and be sure you use the same vocabulary in your responses. This alignment is so important because it will help you assess the gap (often unexpectedly wide) between the patient's expectations and the actual medical situation.[20]

If a patient is in denial, it is often helpful not to confront the denial at the first interview. Denial is an unconscious mechanism that may facilitate coping and should be treated gently over several interviews. Confrontation about denial at this early time will most likely just raise the patient's anxiety unnecessarily or, even more likely, set up an adversarial or antagonistic relationship.

Invitation (I)

Although most patients want to know all the details about their medical situation, you can't always assume that this is the case. Obtaining overt permission respects the patients' right to know (or not to know). Some examples of ways to address this follow:

"Are you the kind of person who prefers to know all the details about what is going on?"

"How much information would you like me to give you about your diagnosis and treatment?"

"Would you like me to give you details of what is going on or would you prefer that I just tell you about treatments I am proposing?"

Knowledge (K)

Before you break bad news, give your patient a warning that bad news is coming. There's no need to drop a bombshell when you can ease into the topic. This gives your patient a few seconds longer to prepare psychologically for the bad news. Examples of warning statements include:

"Unfortunately, I've got some bad news to tell you, Mr. Andrews."

"Mrs. Smith, I'm so sorry to have to tell you…."[21,22]

When giving your patient bad news, *use the same language your patient uses.* This technique of aligning or matching terminology with the patient is important. For example, if your patient uses the words "growth" and "spread," you should also try to use these words.

Avoid technical, scientific language. You want your patient to clearly understand what you are saying; you don't want the information to be misconstrued. Even the most well-informed patients find technical terms hard to comprehend and remember during enormous emotional turmoil.

Give the information in small chunks and clarify that the patient understands what you have said at the end of each chunk (and you may need to repeat this several times, particularly when the patient looks nonplussed even if they say they understand): For example: "Do you see what I mean?" or "Is this making sense so far?" Ask often.

Tailor the rate at which you provide information to your patient. If the indication is that your patient understands perfectly so far, move on to the next piece of information. If he or she isn't clear, go over the information again.

As emotions and reactions arise during this discussion, acknowledge them and respond to them. (See the following step below for details.)

Empathy (E)

For most physicians, responding to our patients' emotions is one of the most difficult parts of breaking bad news. In our effort to alleviate our own discomfort and lighten some of our patients' burden, it is often tempting to withhold some of the information, downplay the severity of the situation, or give a more hopeful prognosis than we should. Although these tactics may reduce stress for you and your patients in the short term, they are likely to result in long-term problems for both of you, and you may discredit yourself in the process. It is much more useful—and more therapeutic—to acknowledge patients' emotions as they arise and to address them. The technique that is most useful for this task is called "the empathic response," and it comprises three straightforward steps:

Step 1: Listen for and identify the emotion (or mixture of emotions). If you are not sure what emotion the patient is experiencing, you can use an exploratory response, such as "How does that make you feel?" or "What do you make of what I've just told you?"

Step 2: Identify the cause or source of the emotion, which is most likely to be the bad news that the patient has just heard.

Step 3: Show your patient that you have made the connection between the above two steps—that is, that you have identified the emotion and its origin. Examples might include:

"Hearing the result of the bone scan is clearly a major shock to you."

"Obviously, this piece of news is very upsetting."

"Clearly, this is very distressing."

It may be useful to colloquialize the response: "That's not what you wanted to hear, I know."

Empathic responses help to validate your patient's feelings and relate the response to you: "I wish the news were better." You don't have to experience the same feeling to provide an empathic response; it simply shows your perception of the patient's emotions.

Validation. Once you have shown empathy and identified and acknowledged your patient's emotion, you are ready to validate or normalize his or her feelings. You might use a phrase such as "I can understand how you can feel that way." To minimize feelings of embarrassment and isolation, let your patient know that showing emotion is perfectly normal.

Combining empathic responses with exploratory responses (if needed) and then validating your patient's feelings (in that order) should show him or her that you understand the human side of the medical issue and that you recognize these feelings are normal.[23]

Strategy and summary (S)

One of the best ways to prepare a patient for participation in treatment decisions is to ensure that he or she understands the information you have provided. Check frequently to make sure you and your patient are both on the same page. Before the discussion ends, summarize the information in your discussion and give your patient an opportunity to voice any major concerns or questions. If you do not have time to answer them right at that moment, you can tell your patient that these issues can be discussed in detail during your next interview. You and your patient should go away from the interview with a clear plan of the next steps that need to be taken and the roles you both will play in taking those steps.

Conclusion

Breaking bad news is frequently a tense and distressing experience for both the patient and the physician. Messengers of bad news often inadvertently identify themselves with the negative aspects of the message.[5] Your patients' emotional responses will be difficult to withstand unless you have a strategy with which to address them. Without a plan for addressing these issues, you may attempt to downplay the bad news by only revealing part of the information. This could be disastrous—the patient may be reluctant to participate in decision-making. Your being less than honest or thorough could erode the patient's trust in you as his or her physician.

The S-P-I-K-E-S protocol provides steps that are easy to remember and can be practiced until you feel more comfortable breaking bad news. The empathic, exploratory, and validating responses should also help you to support the patient, an essential

psychological intervention for distress. In practice, the S-P-I-K-E-S protocol has been found to be easily learned and has been shown to increase physicians' sense of competence in this difficult area.

The task of breaking bad news will never be easy, but having a plan of action and knowing that you can support your patient through this difficult time should help considerably.

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