Is There a Good Way to Break Bad News? Utilization of the SPIKES Protocol In Family Meetings

PRESENTED BY
KEN MEEKER, LMSW
PALLIATIVE CARE SOCIAL WORKER
MONTEFIORE MEDICAL CENTER
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Objectives

- To define “bad news” in a medical setting
- To understand the barriers to physicians delivering bad news effectively
- To introduce and break down the six components of the SPIKES Protocol
- To position the palliative care social worker as an advocate and teacher for junior medical staff
Definition of Bad News

“...any information which adversely and seriously affects an individual’s view of his or her future.”

- Recipient’s expectations and level of understanding have an important bearing on the impact of bad news.
What Constitutes Bad News in a Medical Setting?

- New diagnosis of a potentially life-threatening illness
- Patient’s condition suddenly changes or is rapidly declining
- Curative treatments are no longer effective or not an option
- Devastating/disappointing test results
- Limited or poor prognosis
- Shift toward comfort care and hospice
What Do Patients Want?

- Most patients want the truth
  - Survey results (1982):
    - 96% wished to be told their cancer diagnosis
    - 85% wanted realistic estimate of life expectancy
  - Assists patients with quality-of-life decision making
How We Deliver Bad News Matters

- Because it can affect the patient’s:
  - Understanding of information shared by MDs
  - Satisfaction with medical care
  - Level of hopefulness
  - Psychological/emotional adjustment

- In a qualitative study, surviving family members judged the most important features of delivering bad news to be:
  - Attitude/manner of the person who gave the news
  - Clarity of the message
  - Privacy
  - Having their questions answered
Barriers to Breaking Bad News

Why it can be hard for MDs to deliver bad news:

- Lack of training; inexperience
- Anxiety
- Burden of responsibility/inadequacy
  - Going back on your word; sense of failure
- Fear of negative responses and strong emotional reactions
- Uncertainty about patient’s and family’s expectations
- Fear of destroying patient’s sense of hope
The Six Steps of S-P-I-K-E-S Protocol

Step 1: S - Setting Up the Interview
Step 2: P - Assessing the Patient’s Perception
Step 3: I - Obtaining the Patient’s Invitation
Step 4: K - Giving Knowledge and Information to the Patient
Step 5: E - Addressing the Patient’s Emotions with Empathic Responses
Step 6: S - Strategy and Summary
S – Setting/Set-up

- Privacy
  - Interview room (close door)
  - Patient’s room (draw curtain)
- Involve significant others
  - Ask patient who she’d like to have present
    - Important: Who will take on role of spokesperson?
    - “Family” = Blood relatives, friends, neighbors, co-workers, clergy
- Book interpreter, if needed
- Have tissues available!
- Pre-meeting, check in with participating health care providers (IDT) to identify roles and discuss objectives
S – Setting/Set-up (con’d)

- Manage time constraints
  - Allow adequate time for meeting
    - Establish boundaries!
- Avoid interruptions
  - Silence/turn off beepers and cell phones
- Sit down (close to patient, if possible)
  - Avoid barriers between patient and you
- Make connection, look attentive
  - Maintain eye contact
  - Use “active listening” skills
    - Allow for silence
    - Show respect by not interrupting or overlapping
    - “Moscow technique” – slight delay in responding
    - Repetition – reflecting and restating patient’s words
Introductions = good icebreaker
- Names
- Relationship to patient

Explain what palliative care is
- “Most people don’t know what palliative care is. May I explain that to you?”

Check in with patient and family
- “How is everyone doing”
- “How are you all holding up?”
P − Perception

“Before you tell, ask”

- Explore how patient (and family) perceives his/her medical condition, and how serious it is, with open-ended questions:
  - “What’s your understanding of your current medical condition?”
  - “What have the doctors told you so far?”
- Reflect patient’s language and vocabulary in your responses
  - Creates alignment with patient
- Gauge patient’s (and family’s) level of medical literacy to tailor your presentation of bad news
• Opportunity to correct misinformation

• Identify/note signs of denial in patient
  ○ Denial is a coping mechanism that may present as:
    ▶ Wishful thinking
    ▶ Omission of unfavorable medical details
    ▶ Unrealistic expectations of treatment
  ○ May increase in direct proportion to the severity of the illness
I - Invitation

*How much does the patient want to know?*

- Obtaining permission from the patient to report medical information respects his/her right to know or to choose NOT to know. Explore with Qs:
  - “How much information would you like me to give you about your diagnosis and treatment?”
  - “Would you prefer I speak with your family alone and then come back to share with you what we discussed?”
    - Patients may need loved ones to filter the info for them

- Consider issues of race, ethnicity, culture, religion, and socioeconomic status
“Warning shot” can be helpful to prepare patient/family members for bad news

- “I’m so sorry to have to tell you this…”
- “I’m afraid I have some bad news to share…”
- “Some of the news we have to share today may be difficult to hear.” (pause, allow silence)
- “I wish the news was better.”
Five Helpful Guidelines for Delivering Bad News:

1) Use language that matches (“aligns”) with patient’s level of education, comprehension, and vocabulary

2) Avoid technical, scientific jargon and acronyms – keep it simple (Use “spread” rather than “metastasized”)

3) Deliver the information in a sensitive, but direct manner

4) Give information in small chunks and then stay quiet for a few seconds (pause frequently)

5) If prognosis is poor, avoid statements that express futility (e.g., “There is nothing more we can do for you.”)
Emotional responses can include:

- Crying (tearfulness to sobbing); anger/rage; sadness; anxiety; relief; denial; shock; disbelief; grief; isolation/withdrawal; fear; blame; guilt; shame; silence; numbness; the need to flee the room
- Some may intellectualize as a form of denial

Patient’s reaction may be impacted by his/her psychosocial context:

- Financial/relational/practical problems
- Timing of life events (e.g., weddings; births; graduations)
“The Empathic Response” – 4 Steps:

1) Observe the emotion by listening quietly and attentively (use active listening skills)
   - “Bearing witness” – a powerful therapeutic tool

2) Identify and acknowledge the emotion
   - “I can see this news is very upsetting to you. Can you tell me about what you’re feeling?”

3) Identify the cause/source of the emotion
   - Usually connected to the bad news, but it may center on other concerns (e.g., “What will happen to my children?”)
   - If not sure, explore with open-ended questions (e.g., “What worries you most about what I’ve told you?”)

4) Show the patient that you have made the connection between the emotion and the reason behind it
   - Move closer to patient; use touch if it feels right
E – Empathy/Emotions (con’d)

- **Validate** and **Normalize** patient’s emotions
- Combining empathic, exploratory, and validating responses allows you to “join” with the patient and expresses solidarity and support
- Resist the temptation to make things better
  - Often a physician's reaction to his/her sense of helplessness or feelings of failure
  - Avoid platitudes
- Don’t ignore your own feelings
Summarize the clinical information and ask if the patient understands it

- Ask questions to uncover discrepancies in comprehension and clarify them if there are

Ask patient if he/she is ready to discuss treatment options (revisit “Invitation”)

If so, make the patient a partner in the decision-making process

- Honors right of self-autonomy and patient’s “voice”
- Inquiring what the patient’s goals/wishes are can engender hope in the patient
• Don’t pressure the patient to make a decision on the spot, but encourage him to take some time
• Identify goals of care with open-ended Qs:
  o “What is most important to you right now?”
  o “What are your greatest concerns/fears/hopes?”
• Reframe goals using “wish” statements
• Identify patient’s support system; sources of emotional/practical support
• Ask if a follow-up meeting would be helpful
• Establish a plan for “next steps”
  o What treatment plan will focus on:
    ✷ Pain/symptom control
    ✷ Relief of emotional distress
    ✷ Concrete services for family
    ✷ Discharge (e.g., hospice/palliative care services)
Questions?

Thank you

Contact:
Ken Meeker, LMSW
Palliative Care Social Worker
Montefiore Medical Center
kmeeker@montefiore.org
References


Search SPIKES demonstration videos on by Robert Buckman, MD, PhD, on YouTube.