Breaking Bad News

Discussing difficult issues with patients and families

“People want a peaceful, dignified, comfortable death but they do not want it quite yet.” Nina Ainslie, MD

Most patients want accurate diagnostic and prognostic information; however, they also want good news and they want hope.

Physicians do a bad job at estimating prognosis. They are consistently overoptimistic (by a factor of 5). The longer the duration of the doctor-patient relationship and the more recently they have seen the patient, the more overoptimistic they are.

Only 37% of physicians favored giving a patient an accurate prognosis, even if asked.

(Christakis et al: Estimation and determinants of error in doctors’ prognoses in terminally ill patients. BJU Feb 2000)

Prognosis is in fact very difficult to determine. In the SUPPORT study, the median likelihood of survival for 2 months 1 week prior to death was 50%.
Collusion in doctor-patient communication about imminent death
(The et al BMJ Dec 2000)
Followed 35 patients with small cell lung cancer from diagnosis to death. All but 6 cases followed a similar trajectory. For these 29 patients discussion of prognosis and illness trajectory was avoided by focusing on treatment calendar and “recovery plot”.

Patients and families colluded with doctors to foil discussion of larger picture. They “seemed to accept gratefully every opportunity offered by doctors to ‘forget’ the future”.

Collusion in doctor-patient communication about imminent death
(The et al BMJ Dec 2000)
However, once it became clear that death was imminent, many patients and families felt regret about some of the medical choices they had made and over lost opportunities for connection.

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Both doctors and patients find discussion of prognosis anxiety provoking and try to avoid it. Focusing on “treatment calendar” in order to avoid discussion of prognosis may lead to inappropriate care, and failure to make peace prior to death.

Breaking Bad News
From R. Buckman MD “How to Break Bad News”
- Getting started - physical context, who should be there, starting off.
- What does the patient know?
Breaking bad news
- What does the patient want to know?
  Does patient want to be informed and make decisions, or would they prefer to delegate that responsibility?

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- Sharing information - aligning, information in small chunks, no med speak, check reception, reinforce and clarify (written material), listen for the patient’s concerns.

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- Responding to the patient’s feelings - shock, disbelief, denial, displacement, anxiety, anger, guilt.
  Physician responses include closed question, hostile response, open question, empathic response - only last two are helpful.

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- Planning and follow-through - discuss patient’s problem list, make and explain plan, identify sources of support, make a contract. There is always a plan!

Breaking bad news
- Be aware of your own feelings. If you are not aware of them you are doomed to act them out to the detriment of your mental health and your relationship with your patients.

Breaking bad news
- Be comfortable with being uncomfortable. Learn to be present with difficult feelings. There are things you can’t go around, you have to go through them.
Common mistakes
- Talking not listening.
- Using med speak.
- Acting out.

Do Not Resuscitate Orders
- Give your opinion - identify it as an opinion, state why you feel that way, listen to patient or family's concerns. For some patients, consider the "discuss but don't offer" option.
- Emphasize what you will do (palliative care) not just what you won't do.

Do Not Resuscitate Orders
- Reduce guilt - acknowledge that all choices are bad and remind them what the choices are, ask what the patient would want, not what they would want for the patient, give your opinion or usual practice.

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Physicians need to be aware of our own difficulties in dealing with terminally ill patients and our tendencies to use treatment calendars to avoid difficult discussions. There is no way to make it ok.

Breaking Bad News
Don't just do something- sit there!