

# Breaking Bad.....News

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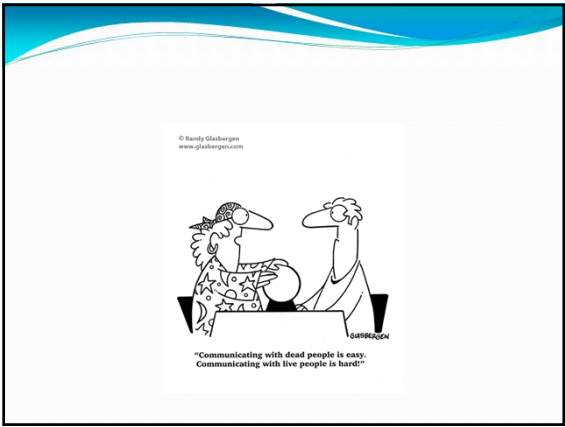
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## Objectives

- Discuss the SPIKES protocol for breaking bad news.
- Discuss how to clarify goals of care with patients with a poor prognosis, and their families
- Evaluate methods of initiating conversations about advance directives and surrogacy

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• “Almost invariably, the act of communication is an **important part of therapy**; occasionally it is the only constituent. It usually **requires greater thought and planning than a drug prescription**, and unfortunately it is **commonly administered in sub-therapeutic doses.**”

• Rob Buckman MD, (Father of the SPIKES protocol)

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### So What Is Bad News?

- Anything “serious”
- Poor prognosis
- New diagnosis
- Old diagnosis taking a turn for the worse or needing a new plan of care
  - Ex: Starting insulin, starting nebulized medications
- “Crucial Conversations”
  - Stakes are high
  - Opinions vary
  - Emotions run strong

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- One of the hardest things we do
- Studies show patients think we can do better
- Patients want to have information about their diagnosis and prognosis, even when the news is worse than expected
- These conversations don’t “destroy hope”

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## Patient's Preferences

- Direct, empathetic communication
- Information about the diagnosis
- Information about the prognosis
- If the illness is likely to affect their quality of life
- Inclusion of a family member or trusted friend
- Encouragement to ask questions
- Information that is neither overly optimistic nor overly pessimistic
- Practical information

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## SPIKES Protocol for Breaking Bad News

- Setting
- Perception
- Invitation
- Knowledge
- Empathize/Emotion
- Summary/Strategy

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## SETTING Up the Interview

- Arrange for some privacy
- Involve desired significant others
- Sit down
- Make connection with the patient
- Manage time constraints and interruptions
- Prepare before the meeting

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## Assessing the Patient's PERCEPTION

- Find out what the patient, or family, knows. Make no assumptions
- Before you tell, ask
- “What have you been told about your medical situation so far?”
- “What is your understanding of your illness?”
- Consider giving a brief overview

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## Obtaining the Patient's INVITATION

- Find out if, when and what they want to know
- “Would you like me to tell you about your test results?”
- “Would you like me to tell you the specifics, or just sketch out the results and spend more time discussing the treatment plan?”
- “Would it be ok if we discussed something that has been worrying me?”

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## Giving KNOWLEDGE and Information To the Patient

- If appropriate, use a “warning shot.”
- “I’m afraid the situation is worse than we thought.”
- Then pause
- Use language the patient and family will understand
- Avoid medical jargon
- Give info in small chunks, and let it sink in
- Periodically check the patient’s understanding
- Never say “There is nothing more we can do for you.”

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## Addressing the Patient's EMOTIONS With EMPATHY

- Observe for any emotion
- Identify the emotion
- Identify the reason for the emotion
- Make a connection. "I wish the news were better."
- "You're right, this is a terrible situation."
- Therapeutic silence
- Touch, if appropriate

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## How to Address Emotions: NURSE

Name	• I can see that this is very upsetting
Understand	• I can't imagine how hard this is for you
Respect	• You're doing all the right things and asking the right questions
Support	• I'm going to walk this road with you
Explore	• Tell me more about what worries you

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## STRATEGY and SUMMARY

- Provide a summary of what you said, or have the patient explain it in their own words
- Make a plan for treatment or follow up
- "I want to see you again in 2 days. Write down any questions."
- Patients who have a clear plan for the future are less likely to feel anxious and uncertain

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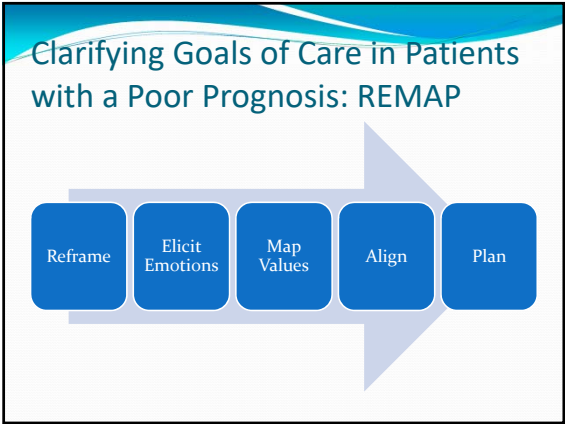
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### REFRAME the situation

- Studies show that patients and families perceive a conversation about goals of care to require disruption of an existing routine, followed by a process of searching and then reconfiguration
- “We’re in a different place now. Further treatments may be too hard on you.”
- “What we are doing is not working.”

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### Elicit EMOTION

- “Tell me what’s going through your mind.”
- “What worries you the most about this?”
- “It’s understandable that you would feel sad when thinking about these things.”
- Listen for the story

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## MAP Values

- Learn more about the patient as a person before talking about treatments.
- “Tell me what is most important to you given that time is limited?”
- “Tell me about some of the things you enjoy doing?”
- “Have you ever filled out a living will?”

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## Align

- Aligning team goals with the goals of the patient/family
- Reflecting back values shows your patient that you were listening.
- “Your desire for your mother to get stronger makes perfect sense.”
- “I’m hearing that what’s important to you is this....So let’s work on .....”
- “If you patient asks for something impossible, try “I wish.....”

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## PLAN treatments

- Depends on the values heard in the mapping phase
- “You said that being at home is important. Let’s help you do more of that.”
- “Given what you have told me, I propose we do this...”
- Can discuss what you do not think will achieve the patient’s goals: “When your heart stops and you are near the end of life, we won’t use machines to try to keep you going; instead we’ll let you pass naturally and use medications to make sure you are comfortable.”

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## What Ifs

"Do everything doctor."	• Don't assume that means full code.
"There must be something more you can do."	• Talk about what you CAN do
"We want to try _____ anyway"	• Consider a time limited trial
"She's a fighter."	• "Yes she is, and I want to help her achieve her goals."
The patient or family can't decide	• "We don't have to have a decision today."

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## Handling Difficult Questions

- e.g. "Is it cancer?" "Am I dying?"
- Find out the patients perception that lead to the question: "What makes you feel like you have cancer?"
- "You asked about cancer, is that something you would like to talk about?"
- Confirm the patient's thoughts if they are correct
- Provide time for emotions
- Provide support.
- Assure continuity of care.

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## Collusion

- When you are asked to withhold medical information from the patient
- Explore that person's or family's feelings, reasons
- Acknowledge their motives. It could be cultural
- Explain the strain that can place on relationships
- Explain that the patient probably already knows
- Offer to assess the patient's understanding
- Reassure

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## Dealing With Anger

- Acknowledge the anger. "You seem very angry."
- Invite them to explain the cause. "Help me understand what is making you so angry."
- Listen
- Do not be defensive
- Focus on their feelings
- Apologize if appropriate. Help to correct any wrongs.
- Clarify. "It must be so difficult for you to see him in pain."

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## Patients Who Do Not Want To Talk

- Denial
- Lack of knowledge
- Depression
- Dementia
- Disengagement
- Talking to someone else
- Want to forget

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## Handling Denial

- Coping mechanism
- Only abnormal when it is an absolute barrier to understanding
- Look for a window: "since this may be my last vacation....."
- Tends to lessen with time
- Don't argue over facts

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**“We are waiting for a miracle.”**  
**“AMEN”**

<b>Affirm</b>	• “I am hopeful, too.”
<b>Meet</b>	• “I join you in hoping for a miracle.”
<b>Educate</b>	• “And (Not But) I want to speak to you about some medical issues.”
<b>No matter what</b>	• “No matter what happens, I will be with you every step of the way.”

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**Initiating Conversations about Advance Care Planning**

<b>Ask a straightforward question</b>	• “Have you talked with anyone about a living will or AD?”
<b>Ask about personal experience</b>	• “Have you been with family or friends at the end-of-life?”
<b>Ask about a surrogate or proxy decision maker</b>	• “Who would be the best person to help us make decisions if you were too sick to do so?”
<b>Ask about a living will</b>	• “Do you have an Advance Directive or Living Will?”
<b>Ask about their preferred place of death</b>	• “When your time comes, would you prefer to be at home, or a hospital, or a nursing home?”
<b>Ask about comfort or longevity</b>	• “When that time comes, what is more important- quality of life or length of life?”

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**Normalize it**

- Every new patient
- “I ask all of my patients this.”
- Every annual exam, or Medicare Wellness Visit
- If you would not be surprised if that patient died within the next 12 months.

- It’s an evolving process that takes time.
- Make it portable. Make it obvious in the chart.

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## Surrogate Decision Making

- Advance directives-
  - outline surrogates (Durable Power of Attorney for Health Care),
  - healthcare treatment (Living Will or Directive to Physicians)
  - physician orders (Inpatient DNR, OOH DNR, POLST)
- Surrogates-have the same authority for decision making as the incapacitated patient. They must be available, and utilize either substituted judgment or the “best interest” standard.

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## Substituted Judgment

- Based on previously expressed statements or actions of the patient.
- “If he could wake up for 15 minutes, understand his current medical situation completely, and then had to go back into it, what would he tell us to do?”
- Consider patient’s values and wishes
- “Did she ever talk about her wishes?”

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## “Best Interest” Standard

- What a reasonable person in similar circumstances would decide.
- Parents are expected to make decisions that represent the child’s “best interests”
- May incorporate the patient’s values and preferences.

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## Discussing DNR Orders

- CPR – 1959. First use was in operating and recovery rooms.
- Meant to resuscitate healthy patients who developed sudden cardiac arrest in the OR
- Over time it began to be used throughout the hospital
- The general public thinks CPR works 60-85% of the time. Actual survival to hospital discharge is ~10-15% for all patients, and < 5% for the elderly and those with serious illness.

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## CPR Outcomes

- National Registry of Cardiopulmonary Resuscitation
- Over 14,000 cases.
- Only 17% survived to discharge.
- Only 10% for asystole and PEA
- 84% came from home, but only half of those who survived returned to home

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## CPR Outcomes

- Factors predicting survival: MI, CAD, HTN
- Factors predicting failure: sepsis, Cr > 1.5, Metastatic cancer, dementia, dependent status
- The cause of arrest is usually associated with advanced chronic illness rather than an easily reversible acute event (isolated arrhythmia).

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## CPR Outcomes

- Return of Spontaneous Circulation (ROSC) rates range from 20-50%
- Cancer-6.7% survival to discharge in a recent meta-analysis
- Floor patients- 10%
- ICU patients-2.2%. No neurologic data included
- Dialysis patients- 14% survival to discharge, 3% survival at 6 months
- Overall 15%, or 1 in 6 patients may survive to discharge, and they are at risk of permanent neurological and functional impairment.
- Statistics haven't improved in 40 years

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## DNR and AND

- Use language that the patient will understand. Don't get into too many specifics: "tube down your throat," or "putting on a breathing machine."
- Don't say "Do you want us to do everything?"
- Don't say "If your heart were to stop....." It's ok to say "die" and it helps clarify that CPR is a treatment that tries to reverse death. Say "If you were to die...."

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## DNR and AND

- If goals of care are comfort, then its ok to say "With this in mind, I do not recommend the use of artificial or heroic means to keep you alive. If you agree, I will write an order in the chart that if you die, no attempt to resuscitate you will be made."
- If the clinical situation is more ambiguous, ask "If you should die in spite of all of our efforts, do you want us to use heroic measures to attempt to bring you back?" Or "How do you want things to be done when you die?"
- If they want more information, describe the purpose, risks and benefits of CPR. Start general and become more specific as they ask for it.

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## DNR and AND

- Respond to emotions
- Silence - "...for ills so immeasurable, time and silence are the only medicine." Thomas Jefferson
- Establish a plan: "If you die, we won't use CPR to bring you back. And it sounds like we also need to maximize your comfort. So I would like to talk to you further about...."
- Document

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## DNR or AND Orders, Unreasonable Requests

- Guilt, fear, or distrust of the medical system may be barriers
- Some families need an explicit recommendation to stop all efforts to prolong life
- Some see CPR as a "last best hope"
- If patients are not ready, don't let it distract you from the other important decisions to be made
- Repeat discussion later
- Explain DNR does not mean Do Not Treat

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## Make Recommendations

- Families want to know our advice
- "Given what you have told me about your father, then I recommend...."
- "Some families in this situation would do...."
- Consult if needed
- Time-limited trials

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## Questions?

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- "...for ills so immeasurable, time and silence are the only medicine. I will not, therefore, by useless condolences, open afresh the sluices of your grief, nor, although mingling sincerely my tears with yours, will I say a word more where words are vain..."

- Thomas Jefferson

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