

Annotated Bibliography

Conversations during Serious Illness

Module 1: Sharing Serious News



Aungst H. (2010). How to deliver bad news to patients. *Medical Economics*. Accessed on March 5, 2017 at <http://medicaleconomics.modernmedicine.com/medical-economics/news/modernmedicine/modern-medicine-feature-articles/how-deliver-bad-news-patients>

Baer A, Freer J, Milling D, Potter WR, Ruchlin H, Zinnerstrom KH. (2008). Breaking bad news: use of cancer survivors in role-playing exercises. *J Palliat Med* 11(6): 885-892

PURPOSE: To teach medical students how to deliver a diagnosis of cancer using role-play with a cancer survivor volunteer.

METHOD: Medical students participated in a curricular module on "breaking bad news." Its novel aspect was the inclusion of role -playing exercises during which the student communicated the initial diagnosis of cancer to a cancer survivor volunteer. The clinical scenario was based on the volunteer's own history of cancer. The exercise required the student to become knowledgeable about the volunteer's cancer and its mode of presentation, deliver the diagnosis using previously demonstrated methods, and then receive verbal feedback from the volunteer. A panel discussion with the cancer survivor volunteers concluded the module. The efficacy of this curricular module was assessed by the students' performance during the role-playing exercise, gain in confidence in communicating bad news, and overall rating of the learning experience.

RESULTS: The interaction of the students with the cancer survivors was the strength of this curriculum, providing the students with an important perspective on physician-patient relationships and coping with cancer. The students demonstrated a high level of adherence to preferred communication techniques, gained significant confidence with the task of "breaking bad news," and were very satisfied with the module. Participation in these role-playing exercises by the cancer survivor volunteers was viewed as emotionally demanding but also rewarding. Recruitment and retention of the volunteers were not obstacles to this activity.

CONCLUSION: Role-playing with cancer survivor volunteers can be an effective method of teaching medical students how to communicate bad news.

Baile WF, Buckman R, Lenzia R, Globera G, Bealea EA, Kudelkab AP. (2000). SPIKES—A six-step protocol for delivering bad news: Application to the patient with cancer. *The Oncologist*, 5(4): 302-311

The authors describe a protocol for disclosing unfavorable information—"breaking bad news"—to cancer patients about their illness. Straightforward and practical, the protocol meets the requirements defined by published research on this topic. The protocol (SPIKES) consists of six steps. The goal is to enable the clinician to fulfill the four most important objectives of the interview disclosing bad news: gathering information from the patient, transmitting the medical information, providing support to the patient, and eliciting the patient's collaboration in developing a strategy or treatment plan for the future. Oncologists, oncology trainees, and medical students who have been taught the protocol have reported increased confidence in their ability to disclose unfavorable medical information to patients. Directions for continuing assessment of the protocol are suggested.

Bohner G, Chaiken S, Hunyadi P. (1994). The role of mood and message ambiguity in the interplay of heuristic and systematic processing. *Eur J Soc Psych*, 24:207-21.

The mechanisms by which mood states influence attitude judgments in persuasion settings are delineated in terms of current dual-process theorizing. With an emphasis on mechanisms that may operate when the evaluative implications of message content are ambiguous. In a preliminary test of hypotheses concerning such circumstances, college-aged subjects were put into a happy or sad mood and then read a message containing unambiguous strong, unambiguous weak, or ambiguous arguments, which was attributed to a highly credible source (heuristic cue) When message content was ambiguous, sad (as compared to happy) subjects' attitudes were more influenced by heuristic processing, and their message-related thoughts were biased by the heuristic cue. These and other results are discussed within a dual-processing framework, and compared to other social cognition theorizing on the impact of effect on social judgment.

Bourquin C, Stiefel F, Mast MS, Bonvin R, & Berney A. (2015). Well, you have hepatic metastases: Use of technical language by medical students in simulated patient interviews. *Patient Education and Counseling*, 98:323-330.

OBJECTIVE: This research explored medical students' use and perception of technical language in a practical training setting to enhance skills in breaking bad news in oncology.

METHODS: Terms potentially confusing to laypeople were selected from 108 videotaped interviews conducted in an undergraduate Communication Skills Training. A subset of these terms was included in a questionnaire completed by students (N=111) with the aim of gaining insight into their perceptions of different speech registers and of patient understanding. Excerpts of interviews were analyzed qualitatively to investigate students' communication strategies with respect to these technical terms.

RESULTS: Fewer than half of the terms were clarified. Students checked for simulated patients' understanding of the terms palliative and metastasis/to metastasize in 22-23% of the interviews. The term ambulatory was spontaneously explained in 75% of the interviews, hepatic and metastasis/to metastasize in 22-24%. Most provided explanations were in plain language; metastasis/to metastasize and ganglion/ganglionic were among terms most frequently explained in technical language.

CONCLUSION: A significant number of terms potentially unfamiliar and confusing to patients remained unclarified in training interviews conducted by senior medical students, even when they perceived the terms as technical.

PRACTICE IMPLICATIONS: This exploration may offer important insights for improving future physicians' skills.

Bousquet G, Orri M, Winterman S, Brugiere C, Verneuil L, Revah-Levy A, (2012). Breaking bad news in oncology: a metasynthesis. *J Clin Oncol* 33 (22): 2437-2443.

PURPOSE: The delivery of bad news by oncologists to their patients is a key moment in the physician-patient relationship. We performed a systematic review of qualitative studies (a metasynthesis) that focused on the experiences and points of view of oncologists about breaking bad news to patients.

METHODS: We searched international publications to identify relevant qualitative research exploring oncologists' perspectives about this topic. Thematic analysis, which compensates for the potential lack of generalizability of the primary studies by their conjoint interpretation, was used to identify key themes and synthesize them. NVivo qualitative analysis software was used.

RESULTS: We identified 40 articles (> 600 oncologists) from 12 countries and assessed their quality as good according to the Critical Appraisal Skills Programme (CASP). Two main themes emerged: the patient-oncologist encounter during the breaking of bad news, comprising essential aspects of the communication, including the process of dealing with emotions; and external factors shaping the patient-oncologist encounter, composed of factors that influence the announcement beyond the physician-patient relationship: the family, systemic and institutional factors, and cultural factors.

CONCLUSION: Breaking bad news is a balancing act that requires oncologists to adapt continually to different factors: their individual relationships with the patient, the patient's family, the institutional and systemic environment, and the cultural milieu. Extending the development of the ability to personalize and adapt therapeutic treatment to this realm of communications would be a major step forward from the stereotyped way that oncologists are currently trained in communication skills.

Buckman R. (1992). *How to break bad news: A guide for health care professionals*. Baltimore, MD: Johns Hopkins University Press.

The guide provides a well-organized, thoughtful, and readily assimilated approach to breaking bad news. The author offers a useful model with practical skills to improve the way clinicians understand the process of breaking bad news. The book features clear writing, believable examples, and practical suggestions for clinicians of every specialty.

Burn CL, Hurst SA, Ummel M, Cerutti B, & Baroffio A. (2014). Telling the truth: medical students' progress with an ethical skill. *Medical Teacher*, 36:251-259.

BACKGROUND: Truth-telling is a complex task requiring multiple skills in communication, understanding, and empathy. Its application in the context of breaking bad news (BBN) is distressing and problematic if conducted with insufficient skills.

PURPOSE: We investigated the long-term influence of a simulated patient-based teaching intervention integrating the learning of communication skills within an ethical reflection on students' ethical attitudes towards truth-telling, perceived competence and comfort in BBN.

METHODS: We followed two cohorts of medical students from the preclinical third year to their clinical rotations (fifth year). We analysed their ethical attitudes and level of comfort and competence in BBN before, after the intervention, and during clinical rotations.

RESULTS: Students' ethical attitudes towards truth-telling remained stable. Students feeling uncomfortable or incompetent improved their level of perceived comfort or competence after the intervention, but those feeling comfortable or competent became more aware of the difficulty of the

situation, and consequently decreased their level of comfort and competence.

CONCLUSIONS: Confronting students with a realistic situation and integrating the practice of communication skills within an ethical reflection may be effective in maintaining ethical attitudes towards truth-telling, in developing new skills and increasing awareness about the difficulty and challenges of a BBN situation.

Buss MK, Rock LK, & McCarthy EP. (2017). Understanding Palliative Care and Hospice: A Review for Primary Care Providers. *Mayo Clinic Proceedings*, 92(2):280-286

Palliative care provides invaluable clinical management and support for patients and their families. For most people, palliative care is not provided by hospice and palliative medicine specialists, but rather by their primary care providers. The recognition of hospice and palliative medicine as its own medical subspecialty in 2006 highlighted the importance of palliative care to the practice of medicine, yet many health care professionals harbor misconceptions about palliative care, which may be a barrier to ensuring that the palliative care needs of their patients are identified and met in a timely fashion. When physicians discuss end-of-life concerns proactively, many patients choose more comfort-focused care and receive care more aligned with their values and goals. This article defines palliative care, describes how it differs from hospice, debunks some common myths associated with hospice and palliative care, and offers suggestions on how primary care providers can integrate palliative care into their practice.

Chesanow N. (2016 January 27). Delivering 'bad' vs 'serious' news to patients. www.medscape.com
CSU, Institute for Palliative Care, Advance Care Planning Fundamentals Course

Dickerson A. (2009). Alex Dickerman, 2009 Psychology Today
<https://www.psychologytoday.com/blog/happiness-in-world/200909/delivering-bad-news>

This is a personal account shared by a physician about his memory as a first year resident when he first had to make a call to tell a family member that their loved one had died.

Fallowfield L & Jenkins V. (2004). Communicating sad, bad, and difficult news in medicine. *The Lancet*, 363, 312-319.

In every medical specialty bad, sad, and difficult information must be given to patients and their families. An insensitive approach increases the distress of recipients of bad news, may exert a lasting impact on their ability to adapt and adjust, and can lead to anger and an increased risk of litigation. Many doctors also find these interactions stressful, and in the absence of much effective training they may adopt inappropriate ways of delivering bad news and coping with the emotional fall-out. Recognition of these difficulties has led to many initiatives, ranging from increased communication skills training to the development of guidelines and protocols. We review some of the research on the impact that giving sad, bad, and difficult news has on doctors and patients, and assess whether interventions are helping. We focus mainly on difficulties encountered involving parents in an obstetric or pediatric setting, people in acute trauma situations such as accident and emergency departments, and patients with cancer.

Fallowfield LJ. (1996). Things to consider when teaching doctors how to deliver good, bad, and sad news. *Medical Teacher*, 18(1). Retrieved from EBSCO database.

Poor communication can lead to misunderstandings about the importance of different diagnostic tests, underreporting of key symptoms and side-effects and poor adherence to treatment regimens or willingness to accept advice. Such situations are disturbing for patients and their families and professionally and personally unrewarding for doctors. The reasons for communication failures are complex and include characteristics of both patients and doctors, and the system of health care delivery. However, one of the primary reasons for the sorry state of affairs is the inadequate training given to most doctors in effective communication skills. This paper looks at some of the difficulties experienced by patients and their doctors and considers how to help correct the communication deficiencies.

Finlay I & Dallimore D. (1991). Your child is dead. *British Medical Journal*, 302:1524-1525.

OBJECTIVE: To determine parent's views on how death of their children should have been handled.
DESIGN: Retrospective questionnaire survey of parents who had experienced death of their child.
SETTING: Charitable organisation of bereaved parents.
SUBJECTS: 150 bereaved parents, all members of the organisation, of whom 120 (80%) participated

voluntarily in the study.

MAIN OUTCOME MEASURES: Child's age; date and cause of death; details of person breaking the news and handling of the interview; time parents spent with dead child, their attitude to requests for organ donation, and follow up support received.

RESULTS: 122 children's deaths were described; the largest single group was due to road traffic accidents, 16 were suicides, and eight were murders. Twice as many interviews were rated as sympathetically or reasonably handled as badly or offensively handled (68 v 34). The interview ratings depended on the sensitivity and personal skills of the interviewers rather than on their previous contact or professional position; police were rated as more sympathetic than doctors and nurses. Of 109 respondents, 81 had seen their child's body, 44 of whom thought that sufficient time had been denied. Of the 28 parents who did not see the body, 17 subsequently stated their regret. In 82 parents organ donation had not been discussed. Only 16 parents recorded any follow up support from hospital staff and very few support at the time.

CONCLUSIONS: The consistency of the responses suggests a serious need to revise the in service training and education of the police and health professionals in their approach to informing of death; organ donation should be discussed sensitively and parents allowed time with their dead child with fewer restrictions.

Goleman D. (2007). *Social Intelligence: The New Science of Human Relationships*, Bantam Books, New York City, NY

Good DJ, Lyddy CJ, Glomb TM, Bono JE, Brown KW, Duffy MK, Baer RA, Brewer JA, & Lazar SW. (2016). Contemplating mindfulness at work: An integrative review. *Journal of Management*, 42(1):114-142.

Gorniewicz J, Floyd M, Krishnan K, Bishop TW, Tudiver F, & Lang F. (2017). Breaking bad news to patients with cancer: A randomized control trial of a brief communication skills training module incorporating the stories and preferences of actual patients. *Patient Education and Counseling*, 100: 655- 666

OBJECTIVE: This study tested the effectiveness of a brief, learner-centered, breaking bad news (BBN) communication skills training module using objective evaluation measures.

METHODS: This randomized control study (N=66) compared intervention and control groups of students (n=28) and residents' (n=38) objective structured clinical examination (OSCE) performance of communication skills using Common Ground Assessment and Breaking Bad News measures.

RESULTS: Follow-up performance scores of intervention group students improved significantly regarding BBN (colon cancer (CC), p=0.007, r=-0.47; breast cancer (BC), p=0.003, r=-0.53), attention to patient responses after BBN (CC, p<0.001, r=-0.74; BC, p=0.001, r=-0.65), and addressing feelings (BC, p=0.006, r=-0.48). At CC follow-up assessment, performance scores of intervention group residents improved significantly regarding BBN (p=0.004, r=-0.43), communication related to emotions (p=0.034, r=-0.30), determining patient's readiness to proceed after BBN and communication preferences (p=0.041, r=-0.28), active listening (p=0.011, r=-0.37), addressing feelings (p<0.001, r=-0.65), and global interview performance (p=0.001, r=-0.51).

CONCLUSION: This brief BBN training module is an effective method of improving BBN communication skills among medical students and residents.

PRACTICE IMPLICATIONS: Implementation of this brief individualized training module within health education programs could lead to improved communication skills and patient care.

Greenberg LW, Ochsenschlager D, O'Donnell D, Mastruserio J, & Cohen GJ. (1999). Communicating bad news: a pediatric department's evaluation of a simulated intervention. *Pediatrics*, 103(6):1210-1217.

OBJECTIVE: To determine if pediatric residents and emergency department (ED) fellows could improve their ability to counsel and inform standardized patients (SPs) about bad news.

METHODOLOGY: A crossover, self-controlled design in which trainees were their own control individuals, and SPs provided feedback after the first interview. The setting was the consultation room in the ED of a large children's hospital. The outcome measures included examining the counseling and informing skills of study participants.

RESULTS: Trainees improved their informing skills after being provided feedback in the broad areas of communication and follow-up and in the total number of content areas asked. Their counseling skills improved in two areas: 1) promoting more trust and 2) making parents feel less dependent. Those trainees who scored higher on counseling skills discussed more total and critical content issues with SPs in the study. Trainee feedback revealed a very high rating of the educational process, and the trainees also

felt much more confident about their skills after the first and second sessions.

CONCLUSIONS: Using SPs to teach residents and ED fellows to give bad news is an effective educational process that provides trainees with interactions that simulate real-life experience

Griffiths J, Ewing G, Wilson C, Connolly M, Grande G. (2015) Breaking bad news about transitions to dying: a qualitative exploration of the role of the district nurse. *Palliat Med* 29 (2): 138-146

BACKGROUND: UK District Nurses have an important role in enabling a good death. Patients and families need to know the patient is approaching the dying phase, yet evidence suggests breaking bad news about the patient's transition to dying rarely happens. District Nurses spend a lot of time with patients and families during the dying phase and are ideally placed to recognise and discuss the transition to dying.

AIM: To explore the role of District Nurses in breaking bad news of transition to dying.

DESIGN: Qualitative focus groups.

SETTING: Primary care (District Nurse service); Four National Health Service Trusts, North West England.

PARTICIPANTS: A total of 40 District Nurses across the Trusts, all Registered General Nurse qualified.

Median number of years as a District Nurse was 12.5. All had palliative cancer patients on their caseloads.

RESULTS: District Nurses' role in breaking bad news of transition to dying was challenging, but the conversation was described as essential preparation for a good death. Four main challenges with the conversations were patients' responses to the prognosis (unawareness, denial and anger), timing the conversation, complexities of the home environment and limited preparation in this aspect of their work.

CONCLUSIONS: District Nurses are with patients during their last weeks of life. While other colleagues can avoid breaking bad news of transition to dying, District Nurses have no choice if they are to provide optimal end of life care. While ideally placed to carry out this work, it is complex and they are unprepared for it. They urgently need carefully tailored training in this aspect of their work, to enable them to provide optimal end of life care.

Hoff L, Tidefelt U, Thaning L, Hermeren G. (2007). In the shadow of bad news – Views of patients with acute leukaemia, myeloma or lung cancer about information, from diagnosis to cure or death. *BMC Palliative Care* 6:1.

BACKGROUND: Many studies have been published about giving and receiving bad messages. However, only a few of them have followed the patients all the way through a disease as is done in this study. Many studies have been written about patients' coping strategies. In this study we will keep within the bounds of coping through information only. The aim of the study is to investigate patients' views of information during the trajectory of their disease, whether their reactions differ from each other and whether they differ in different phases of the disease.

METHODS: Twelve patients with malignant haematological diseases or lung cancer were followed with interviews from diagnosis to recovery or into the terminal phase or at most for two years. The method is qualitative, using semi-structured interviews.

SETTING: Orebro University Hospital or the patient's home.

RESULTS: All patients described themselves as well informed from the start but in later phases of their disease some of them came to express a great uncertainty about the progressing disease and about the approaching death. Most of them, regardless of whether they had a haematological malignancy or lung cancer, expressed a wish to be well informed all through the disease and even when the messages were bad. Different strategies for coping with information, however, affected how they then dealt with the information received. Four such coping strategies were found: 1) Information-dependent and accepting; 2) Information-dependent but denying; 3) Medically informed and accepting; 4) Medically informed but denying.

CONCLUSION: To several patients there was an unmet need for information about the progressing disease and the approaching death. To optimize the care of these patients it seems important that the physician is aware of patients' need for information even when the news is bad. Knowing the patient's information strategy could probably function as a key for the physician to communicate with patients on these matters.

Hollyday SL & Buonocore D. (2015). Breaking bad news and discussing goals of care in the intensive care unit. *AACN Advanced Critical Care*, 26(2):131-141.

The intensive care unit is a high-stakes environment in which nurses, including advanced practice registered nurses (APRNs), often assist patients and families to navigate life and death situations. These high-stakes situations often require discussions that include bad news and discussions about goals of care or limiting aggressive care, and APRNs must develop expertise and techniques to be skilled

communicators for conducting these crucial conversations. This article explores the art of communication, the learned skill of delivering bad news in the health care setting, and the incorporation of this news into a discussion about goals of care for patients. As APRNs learn to incorporate effective communication skills into practice, patient care and communication will ultimately be enhanced.

Hsu I, Saha, S, Korthuis PT, Sharp V, Cohn J, Moore RD, & Beach MC. (2012). Providing support to patients in emotional encounters: A new perspective on missed empathic opportunities. *Patient Education and Counseling*, 88(3):436-442.

OBJECTIVE: Studies have repeatedly found that providers miss 70-90% of opportunities to express empathy. Our study sought to characterize provider responses to patients' emotions, with the overall goal of better understanding reasons for lack of empathic response.

METHODS: We analyzed 47 visits between patients and their providers. We defined empathic opportunities as instances where patients expressed a strong negative emotion. We then developed thematic categories to describe provider response.

RESULTS: We found a total of 29 empathic opportunities within 21 visits. Provider responses were categorized as ignore, dismiss, elicit information, problem-solve, or empathize. An empathic statement occurred at some point in the response sequence in 13/29 opportunities(45%). When problem-solving was the initial response, empathic statements rarely occurred in subsequent dialogue. Among the 16 instances with no empathic statements, providers engaged in problem-solving in 8 (50%).

CONCLUSION: Similar to other studies, we found providers missed most opportunities to respond empathically to patient emotion. Yet contrary to common understanding, providers often addressed the problem underlying the emotion, especially when the problem involved logistical or biomedical issues, as opposed to grief.

PRACTICE IMPLICATIONS: With enhanced awareness, providers may better recognize situations where they can offer empathy in addition to problem-solving.

Hulsman RL, Pranger S, Koot S, Fabriek M, Karemaker JM, Smets EM. (2010). How stressful is doctor-patient communication? Physiological and psychological stress of medical students in simulated history taking and bad-news consultations. *Int J Psychophysiol*. 77(1):26-34.

INTRODUCTION: Medical communication can be a stressful experience for both doctors and patients. In particular, inexperienced doctors facing the demanding task of a bad news consultation may experience high levels of distress. The aim of this exploratory study is to test students' differential cardiovascular reactivity to history taking and bad news consultations with a simulated patient, and to test the relation between the students' self-reported stressfulness of the consultation and their cardiovascular response.

METHODS: Fourth and fifth year medical students (n=20) conducted a history taking (HT) and a bad news (BN) consultation in a randomized order with a standardized patient. Heart rate (HR), mean arterial pressure (MAP), cardiac output (CO) and systemic vascular resistance (SVR) were assessed by way of the Finapres-technique in four conditions: rest, reading aloud, and during both consultations. Self-reported stress was assessed before and after each interview using the State and Trait Anxiety Inventory (STAI), and a visual analogue scale (VAS).

RESULTS: Both HT and BN provoked more cardiovascular stress than reading. Bad-news provoked the highest HR and CO responses compared to all other conditions, and had a greater impact when it was the student's first consultation. The STAI and VAS data showed some correlations with the cardiovascular stress measures and a comparable but less significant pattern in stress response.

DISCUSSION: The effect of order of the HT and BN consultations on the students' stress levels suggests an additional impact of novelty and habituation. Unfamiliarity with the patient may enhance the stressfulness of the task of breaking bad news.

Laurie J & Blandford A. (2016). Making time for mindfulness. *International Journal of Medical Informatics*, 96:38-50.

OBJECTIVE: Digital mental wellbeing interventions are increasingly being used by the general public as well as within clinical treatment. Among these, mindfulness and meditation programs delivered through mobile device applications are gaining popularity. However, little is known about how people use and experience such applications and what are the enabling factors and barriers to effective use. To address this gap, the study reported here sought to understand how users adopt and experience a popular mobile-based mindfulness intervention.

METHODS: A qualitative semi-structured interview study was carried out with 16 participants aged 25-38

(M=32.5) using the commercially popular mindfulness application Headspace for 30-40 days. All participants were employed and living in a large UK city. The study design and interview schedule were informed by an autoethnography carried out by the first author for thirty days before the main study began. Results were interpreted in terms of the Reasoned Action Approach to understand behaviour change.

RESULTS: The core concern of users was fitting the application into their busy lives. Use was also influenced by patterns in daily routines, on-going reflections about the consequences of using the app, perceived self-efficacy, emotion and mood states, personal relationships and social norms. Enabling factors for use included positive attitudes towards mindfulness and use of the app, realistic expectations and positive social influences. Barriers to use were found to be busy lifestyles, lack of routine, strong negative emotions and negative perceptions of mindfulness.

CONCLUSIONS: Mobile wellbeing interventions should be designed with consideration of people's beliefs, affective states and lifestyles, and should be flexible to meet the needs of different users. Designers should incorporate features in the design of applications that manage expectations about use and that support users to fit app use into a busy lifestyle. The Reasoned Action Approach was found to be a useful theory to inform future research and design of persuasive mental wellbeing technologies.

Levetown M. (2004). Breaking bad news in the emergency department: When seconds count. *Topics in Emergency Medicine*, 26(1):35-43.

One of the most difficult tasks of an emergency care provider is to inform parents of their child's death. Only a rare physician, nurse, or first-responder training program teaches practitioners how to have this conversation. Yet, the impact of this conversation for parents is lifelong; they report that the interaction with health professionals at time of disclosure either creates long-term peace or haunts them for the rest of their days. Similarly, caregivers may be regretful or heartened by their experiences in meeting the needs of parents in extremis. This article provides recommendations for breaking bad news in the emergency department and training methods for providers confronting the sudden death of a child.

Levine LJ, Burgess SL. (1997). Beyond general arousal: Effects of specific emotions on memory. *Social Cognition* 15:157-81.

Levinson W, Gorawara-Bhat R, Lamb J. (2000). A study of patient clues and physician responses in primary care and surgical settings. *J Am Med Assoc*; 284:1021-7.

CONTEXT: Patients often present clues (direct or indirect comments about personal aspects of their lives or their emotions) during conversations with their physicians. These clues represent opportunities for physicians to demonstrate understanding and empathy and thus, to deepen the therapeutic alliance that is at the heart of clinical care. A paucity of information exists regarding how physicians address the psychological and social concerns of patients.

OBJECTIVES: To assess how patients present clues and how physicians respond to these clues in routine primary care and surgical settings.

DESIGN, SETTING, AND PARTICIPANTS: Descriptive, qualitative study of 116 randomly selected routine office visits to 54 primary care physicians and 62 surgeons in community-based practices in Oregon and Colorado, audiotaped and transcribed in 1994.

MAIN OUTCOME MEASURES: Frequency of presentation of clues by patients during office visits, nature (emotional vs social) and content of clues, and nature of physician responses to clues, coded as positive or missed opportunity.

RESULTS: Fifty-two percent and 53% of the visits in primary care and surgery, respectively, included 1 or more clues. During visits with clues, the mean number of clues per visit was 2.6 in primary care and 1.9 in surgery. Patients initiated approximately 70% of clues, and physicians initiated 30%. Seventy-six percent of patient-initiated clues in primary care settings and 60% in surgical settings were emotional in nature. In surgery, 70% of emotional clues related to patients' feelings about their biomedical condition, while in primary care, emotional clues more often related to psychological or social concerns (80%) in patients' lives. Physicians responded positively to patient emotions in 38% of cases in surgery and 21% in primary care, but more frequently they missed opportunities to adequately acknowledge patients' feelings. Visits with missed opportunities tended to be longer than visits with a positive response.

CONCLUSION: This study suggests that physicians in both primary care and surgery can improve their ability to respond to patient clues even in the context of their busy clinical practices.

Merckaert I, Lienard A, Libert Y et al (2013). Is it possible to improve the breaking bad news skills of residents when a relative is present? A randomised study. *Br J Cancer* 109: 2507- 2514

BACKGROUND: Although patients with cancer are often accompanied by a relative during breaking bad news (BBN) consultations, little is known regarding the efficacy of training programmes designed to teach residents the communication skills needed to break bad news in a triadic consultation.

METHODS: Residents were randomly assigned to a 40-h dyadic and triadic communication skills training programme (n=48) or a waiting list (n=47). A simulated BBN triadic consultation was audiotaped at baseline, and after training for the training group, and 8 months after baseline for the waiting list group. Transcripts were analysed using content analysis software (LaComm). A coder determined the moment of bad news delivery and the relative's first turn of speech regarding the bad news. A generalised estimating equation was used to evaluate residents' communication skills, BBN timing, and the relative's inclusion in the consultation.

RESULTS: Ninety-five residents were included. After training, the duration of the pre-delivery phase was found to be longer for the trained residents (relative risk (RR)=3.04; P<0.001). The simulated relative's first turn of speech about the bad news came more often during the pre-delivery phase (RR=6.68; P=0.008), and was more often initiated by the trained residents (RR=19.17; P<0.001). Trained residents also used more assessment (RR=1.83; P<0.001) and supportive utterances (RR=1.58; P<0.001).

CONCLUSION: This study demonstrates that a training programme that focuses on the practice of dyadic and triadic communication skills can improve the communication skills of the participating residents in a BBN triadic consultation. Such a training should be included in resident curriculum.

Monden KR, Gentry L, & Cox TR. (2016). Delivering bad news to patients. *Baylor University Medical Center Proceedings*, 29(1):101-102.

When physicians lack proper training, breaking bad news can lead to negative consequences for patients, families, and physicians. A questionnaire was used to determine whether a didactic program on delivering bad news was needed at our institution. Results revealed that 91% of respondents perceived delivering bad news as a very important skill, but only 40% felt they had the training to effectively deliver such news. We provide a brief review of different approaches to delivering bad news and advocate for training physicians in a comprehensive, structured model.

Morgans A, Schapira L. (2015) Confronting therapeutic failure: a conversation guide. *Oncologist* 20: 946-951

We reflect on the impact of bad news on both clinician and patient in the setting of cancer treatment failure. We review the classic six-step SPIKES (setting, perception, invitation for information, knowledge, empathy, summarize and strategize) protocol for giving bad news that has been widely adopted since it was first published in this journal in 2005. The goal of such a conversation guide is to describe both the process and the tasks that constitute vital steps for clinicians and to comment on the emotional impact of the conversation on the clinician. Confronting therapeutic failure is the hardest task for oncologists. We offer practical tips derived from a thorough review of the evidence and our clinical experience.

Morgans AK, & Schapira L. (2015). Confronting therapeutic failure: A conversation guide. *The Oncologist*, 20:946-951.

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Morse DS, Edwardsen EA, & Gordon HS. (2008). Missed opportunities for interval empathy in lung cancer communication. *Archives of Internal Medicine*, 168(17):1853-1858.

BACKGROUND: Empathy is important in patient-physician communication and is associated with improved patient satisfaction and adherence to physicians' recommendations.

METHODS: To evaluate empathic opportunities and physician responses, we conducted a qualitative thematic analysis of 20 audiorecorded, transcribed consultations between patients with lung cancer and their thoracic surgeons or oncologists, from a larger observational study of 137 patients in a Veterans

Affairs hospital in the southern United States. Using qualitative analysis, we collaboratively developed themes and subthemes until saturation. Then, each transcript was coded, using grounded theory methods, until consensus was achieved, counting and sequentially analyzing patient empathic opportunities and physician responses.

RESULTS: Subthemes regarding patients' statements about lung cancer included (1) morbidity or mortality concerns, (2) cancer-related symptoms, (3) relationship to smoking, (4) decisions about treatment, (5) beliefs about or mistrust of medical care, (6) factors limiting ability to treat cancer, and (7) confusion regarding cancer status and treatment. We identified 384 empathic opportunities and found that physicians had responded empathically to 39 (10%) of them. Otherwise, physicians provided little emotional support, often shifting to biomedical questions and statements. We defined this phenomenon as missed opportunities for "interval empathy." When empathy was provided, 50% of these statements occurred in the last one-third of the encounter, whereas patients' concerns were evenly raised throughout the encounter.

CONCLUSIONS: Physicians rarely responded empathically to the concerns raised by patients with lung cancer, and empathic responses that did occur were more frequently in the last third of the encounter. Our results may provide a typologic approach to help physicians recognize empathic opportunities and with further development may aid in improving physicians' communication skills.

Murray SA, Kendall M, Boyd K, & Sheikh A. (2005). *Illness trajectories and palliative care*. [British Medical Journal](#), 330(7498):1007-11.

Olds JL. (2011). *Communicating Bad News to Your Patients*. Family Practice Management website, Accessed on August 3, 2017 from <http://www.aafp.org/fpm/2011/1100/p31.pdf>

Orlander JD, Fincke G, Hermanns D, & Johnson GA. (2002). Medical residents' first clearly remembered experiences of giving bad news. *Journal of General Internal Medicine*, 17:825-840.

CONTEXT: Communication of bad news to patients or families is a difficult task that requires skill and sensitivity. Little is known about doctors' formative experiences in giving bad news, what guidance they receive, or what lessons they learn in the process.

OBJECTIVE: To learn the circumstances in which medical residents first delivered bad news to patients or families, the nature of their experience, and their opinions about how best to develop the needed skills.

DESIGN: Confidential mailed survey.

SETTING AND SUBJECTS: All medicine house officers at 2 urban, university-based residency programs in Boston.

MAIN OUTCOME MEASURES: Details of medical residents' first clearly remembered experiences of giving bad news to a patient or family member; year in training; familiarity with the patient; information about any planning prior to, observation of, or discussion after their first experience; and the usefulness of such discussions. We also asked general questions about delivering bad news, such as how often this was done, as well as asking for opinions about actual and desired training.

RESULTS: One hundred twenty-nine of two hundred thirteen surveys (61%) were returned. Most (73%) trainees first delivered bad news while a medical student or intern. For this first experience, most (61%) knew the patient for just hours or days. Only 59% engaged in any planning for the encounter. An attending physician was present in 6 (5%) instances, and a more-senior trainee in 14 (11%) others. Sixty-five percent of subjects debriefed with at least 1 other person after the encounter, frequently with a lesser-trained physician or a member of their own family. Debriefing focused on the reaction of those who were given the bad news and the reaction of the trainee. When there were discussions with more-senior physicians, before or after the encounter, these were judged to be helpful approximately 80% of the time. Most subjects had given bad news between 5 and 20 times, yet 10% had never been observed doing so. Only 81 of 128 (63%) had ever observed an attending delivering bad news, but those who did found it helpful 96% of the time. On 7-point scales, subjects rated the importance of skills in delivering bad news highly, (mean 6.8), believed such skill can be improved (mean 6.6), and thought that more guidance should be offered to them during such activity (mean 5.8).

CONCLUSION: Medical students and residents frequently deliver bad news to patients and families. This responsibility begins early in training. In spite of their inexperience, many do not appear to receive adequate guidance or support during their earliest formative experiences.

Porensky EK & Carpenter BD. (2016). Breaking bad news: effects of forecasting diagnosis and framing prognosis. *Patient Education and Counseling*, 99, 68-76.

OBJECTIVE: Research to support guidelines for breaking bad news is lacking. This study used an experimental paradigm to test two communication strategies, forecasting bad news and framing prognosis, in the context of cancer.

METHODS: In a 2x2 design, 128 participants received bad news in a hypothetical consultation. A videotaped physician presented diagnostic and prognostic information, varying warning (warning shot vs. no warning), and framing (positive vs. negative). Effects on psychological distress, recall accuracy, and subjective interpretations of the news were assessed.

RESULTS: Warning was not associated with lower psychological distress or improved recall. Individuals who heard a positively-framed prognosis had significantly less psychological distress, rated their prognosis better, and were more hopeful than those who heard a negatively-framed prognosis. However, they also showed a trend toward reduced accuracy in recalling prognostic statistics.

CONCLUSIONS: Results contribute to a growing body of literature exploring optimal approaches for communicating bad news in health care.

PRACTICE IMPLICATIONS: Although research in clinical settings is needed to bolster results, findings suggest that when providers use positive framing to reduce distress about prognosis, they should also consider ways to overcome potential reductions in recall accuracy, such as repeating statistical information or supplementing with written information.

Ptacek JT, Eberhardt TL. (1996). Breaking bad news: A review of the literature, *Journal of American Medical Association*, 276(6):496-502.

OBJECTIVE: To review the literature on breaking bad news while highlighting its limitations and describing a theoretical model from which the bad news process can be understood and studied.

DATA SOURCES: Sources were obtained through the MEDLINE database, using "bad news" as the primary descriptor and limiting the sources to English-language articles published since 1985.

STUDY SELECTION AND EXTRACTION: All articles dealing specifically with bad news were examined. These works included letters, opinions, reviews, and empirical studies. Recommendations from these articles were examined, sorted into discrete categories, and summarized.

DATA SYNTHESIS: The 13 most consistently mentioned recommendations (e.g., delivering the news at the patient's pace, conveying some hope, and giving the news with empathy) were examined.

CONCLUSION: Although much has been written on the topic of breaking bad news, the literature is in need of empirical work. Research should begin with the simple question of whether how the news is conveyed accounts for variance in adjustment before moving to more specific questions about which aspects of conveying bad news are most beneficial. It is suggested that the bad news process can be understood from the transactional approach to stress and coping.

Raymond MK. (2009, October). Delivering bad news: Helping your patients retain dire details. *Modern Medicine*. Access July 29, 2017 from <http://www.modernmedicine.com/modern-medicine/news/modernmedicine/modern-medicine-feature-articles/delivering-bad-news-helping-you> (accessed July 28, 2017)

Reed S, Kassis K, Nagel R, Verbeck N, Mahan JD, & Shell R. (2015). Breaking bad news is a teachable skill in pediatric residents: A feasibility study of an educational intervention. *Patient Education and Counseling*, 98:748-752.

OBJECTIVE: Patients and physicians identify communication of bad news as a skill in need of improvement. Our objectives were to measure change in performance of first-year pediatric residents in the delivery of bad news after an educational intervention and to measure if changes in performance were sustained over time.

METHODS: Communication skills of 29 residents were assessed via videotaped standardized patient (SP) encounters at 3 time points: baseline, immediately post-intervention, and 3 months post-intervention. Educational intervention used was the previously published "GRIEV_ING Death Notification Protocol."

RESULTS: The intraclass correlation coefficient demonstrated substantial inter-rater agreement with the assessment tool. Performance scores significantly improved from baseline to immediate post-intervention. Performance at 3 months post-intervention showed no change in two subscales and small improvement in one subscale.

CONCLUSIONS: We concluded that breaking bad news is a complex and teachable skill that can be

developed in pediatric residents. Improvement was sustained over time, indicating the utility of this educational intervention.

PRACTICE IMPLICATIONS: This study brings attention to the need for improved communication training, and the feasibility of an education intervention in a large training program. Further work in development of comprehensive communication curricula is necessary in pediatric graduate medical education programs.

Schmid MM, Kindlimann A, Langewitz W. (2005). Recipients' perspective on breaking bad news: how you put it really makes a difference. *Patient Education and Counseling*, 58(3):244-51.

OBJECTIVE: The goal of this study was to show that physician communication style of breaking bad news affects how the physician is perceived, how satisfied recipients of bad news are with the consultation, and how they feel after the consultation.

METHOD: Female participants (students, N=159) were asked to put themselves in the shoes of a patient receiving the bad news of a breast cancer diagnosis. Participants were randomly assigned to watch one of three prototypical physician communication styles of breaking bad news on videotape: patient-, disease-, or emotion-centered communication.

RESULTS: Results showed that these three prototypical communication styles were perceived very differently and they determined how satisfied participants were with the consultation and how they felt after the consultation. Participants exposed to the patient-centered communication perceived the physician as most emotional, least dominant, most appropriate when it comes to conveying information, most available and most expressive of hope. Also, they reported to be most satisfied with the visit and they showed the least increase in negative emotions.

CONCLUSION: A patient-centered communication style has the most positive outcome for recipients of bad news on a cognitive, evaluative, and emotional level.

PRACTICE IMPLICATIONS: Results of this study provide guidelines to physicians on how to convey bad news.

Sisk B, Frankel R, Kodish E, & Isaacson JH. (2016). The truth about truth-telling in American medicine: A brief history. *The Permanente Journal*, 20(3):15-219.

Transparency has become an ethical cornerstone of American medicine. Today, patients have the right to know their health information, and physicians are obliged to provide it. It is expected that patients will be informed of their medical condition regardless of the severity or prognosis. This ethos of transparency is ingrained in modern trainees from the first day of medical school onward. However, for most of American history, the intentional withholding of information was the accepted norm in medical practice. It was not until 1979 that a majority of physicians reported disclosing cancer diagnoses to their patients. To appreciate the current state of the physician-patient relationship, it is important to understand how physician-patient communication has developed over time and the forces that led to these changes. In this article, we trace the ethics and associated practices of truth-telling during the past two centuries, and outline the many pressures that influenced physician behavior during that time period. We conclude that the history of disclosure is not yet finished, as physicians still struggle to find the best way to share difficult information without causing undue harm to their patients.

Skye EP, Wagenschutz H, Steiger JA, Kumagai AK. (2014). Use of interactive theater and role play to develop medical students' skills in breaking bad news. *J Cancer Educ*.29(4):704-8.

Creative arts have been increasingly implemented in medical education. This study investigated the use of interactive theater and role play with professional actors in teaching breaking bad news to medical students. The objectives were to explore the contexts, approaches, experiences, and reactions in giving and receiving bad news. Second-year medical students participated in a required educational session that utilized interactive theater which helps students learn about the issues of breaking bad news to a patient with cancer. Following the interactive theater piece, professional actors provided students role play experiences in small groups with breaking bad news. Anonymous evaluation surveys were given out to all second-year medical students at the conclusion of the breaking bad news session. Surveys contained quantitative and qualitative responses. Three years of evaluations were analyzed. A total of 451 (88 %) students completed the evaluations. Comments were thematically analyzed. Ninety-four percent agreed that the theater piece prompted reflection on patient-provider communications, and 89 % agreed that it stimulated discussion on complex issues with breaking bad news. The two most common themes in student comments concerned the importance of realism in the theater piece, and the value of experiencing multiple perspectives. Use of professional actors during the role play exercises enhances the realism and

pushed the students out of their own “comfort zones” in ways that may more closely approximate real life clinical situations. Interactive theater can be a potentially powerful tool to teach breaking bad news during medical school.

Warnock C, Buchanan J, Tod AM. (2017). The difficulties experienced by nurses and healthcare staff involved in the process of breaking bad news. *J Adv Nurs*.73(7):1632-1645.

AIMS: The aim of this study was to explore the difficulties experienced by nurses and healthcare professionals when engaging in the process of breaking bad news.

BACKGROUND: The challenges faced by staff when breaking bad news have previously been researched in relation to particular settings or participants. This study involved staff from diverse settings and roles to develop broader insights into the range of difficulties experienced in clinical practice.

DESIGN: The study used a descriptive survey design involving self-reported written accounts and framework analysis.

METHODS: Data were collected using a structured questionnaire containing a free text section that asked participants to describe a difficult experience they had encountered when involved in the process of breaking bad news. Data were collected from healthcare staff from hospital, community, hospice and care home settings attending training days on breaking bad news between April 2011 and April 2014.

FINDINGS: Multiple inter-related factors presented challenges to staff engaging in activities associated with breaking bad news. Traditional subjects such as diagnostic and treatment information were described but additional topics were identified such as the impact of illness and care at the end of life. A descriptive framework was developed that summarizes the factors that contribute to creating difficult experiences for staff when breaking bad news.

CONCLUSION: The framework provides insights into the scope of the challenges faced by staff when they engage in the process of breaking bad news. This provides the foundation for developing interventions to support staff that more closely matches their experiences in clinical practice.

Warnock C, Tod A, Foster J, Soreny C. (2010). Breaking bad news in inpatient clinical settings: role of the nurse. *J Adv Nurs*. 66(7):1543-55.

AIM: This paper is a report of an exploration of the role of the nurse in the process of breaking bad news in the inpatient clinical setting and the provision of education and support for nurses carrying out this role.

BACKGROUND: The term ‘breaking bad news’ is mostly associated with the moment when negative medical information is shared with a patient or relative. However, it can also be seen as a process of interactions that take place before, during and after bad news is broken. Little research has been conducted exploring the role of the nurse in the process of breaking bad news in the inpatient clinical setting.

METHODS: A questionnaire was developed using Likert scales and open text questions. Data collection took place in 2007. Fifty-nine inpatient areas took part in the study; 335 questionnaires were distributed in total and 236 were completed (response rate 70%).

RESULTS: Nurses engaged in diverse breaking bad news activities at many points in care pathways. Relationships with patients and relatives and uncontrolled and unplanned events shaped the context in which they provided this care. Little formal education or support for this work had been received.

CONCLUSION: Guidance for breaking bad news should encompass the whole process of doing this and acknowledge the challenges nurses face in the inpatient clinical area. Developments in education and support are required that reflect the challenges that nurses encounter in the inpatient care setting.

Zitter J. (2017). *Extreme measures*. New York: Penguin Random House

Website resources:

<https://data.medicare.gov/data/hospice-compare>

These data allow you to compare the quality of care provided by Medicare-certified hospice agencies throughout the nation.

<http://wnpr.org/post/end-life-care-us-0>

NPR “Where We Live” program in 2017 focusing on end of life care and hospice care nationally.

[https://www.nationalcoalitionhpc.org/National Consensus Project for Quality Palliative Care](https://www.nationalcoalitionhpc.org/National%20Consensus%20Project%20for%20Quality%20Palliative%20Care)

The National Consensus Project for Quality Palliative Care promotes the implementation of **Clinical Practice Guidelines** that ensure care of consistent and high quality, and that guide the development and structure of new and existing palliative care services.

The National Consensus Project for Quality Palliative Care Clinical Practice Guidelines for Quality Palliative Care 3rd edition 2013.

The Clinical Practice Guidelines for Quality Palliative Care promote quality palliative care, foster consistent and high standards in palliative care, and encourage continuity of care across settings. Since there is shared responsibility for palliative care across health care settings, the emphasis is on collaborative partnerships within and among hospitals, community centers, hospices, and home health agencies to ensure quality, continuity, and access to palliative care.

[http://aahpm.org/American Academy of Hospice & Palliative Medicine \(AAHPM\)](http://aahpm.org/American%20Academy%20of%20Hospice%20&%20Palliative%20Medicine%20(AAHPM))

The professional organization for physicians specializing in hospice and palliative medicine. It is dedicated to expanding access of patients and families to high quality palliative care, and advancing the discipline of Hospice and Palliative Medicine through professional education and training, development of a specialist workforce, support for clinical practice standards, research, and public policy.

[https://www.capc.org/Center to Advance Palliative Care \(CAPC\)](https://www.capc.org/Center%20to%20Advance%20Palliative%20Care%20(CAPC))

CAPC provides healthcare professionals with the tools, training, and technical assistance necessary to start and sustain successful palliative care programs in hospitals and other health care settings. CAPC maintains a state by state [report card](#) on access to palliative care in our nation’s hospitals.

[https://www.nhpc.org/Hospice & Palliative Care Organization \(NHPCO\)](https://www.nhpc.org/Hospice%20&%20Palliative%20Care%20Organization%20(NHPCO))

NHPCO is the largest not-for-profit membership organization representing hospice and palliative care programs and professionals in the United States. The organization is committed to improving end of life care and expanding access to hospice care with the goal of profoundly enhancing quality of life for people dying in America and their loved ones.

[http://hpna.advancingexpertcare.org/National Hospice & Palliative Nurses Association \(HPNA\)](http://hpna.advancingexpertcare.org/National%20Hospice%20&%20Palliative%20Nurses%20Association%20(HPNA))

HPNA is the nation’s largest and oldest professional nursing organization dedicated to promoting excellence in palliative nursing care.

[https://www.socialworkers.org/National Association of Social Workers \(NASW\)](https://www.socialworkers.org/National%20Association%20of%20Social%20Workers%20(NASW))

NASW is the membership organization for social workers. It has developed standards for social work practice in palliative & end of life care, and offers specialty certification.

[http://www.npcrc.org/National Palliative Care Research Center \(NPCRC\)](http://www.npcrc.org/National%20Palliative%20Care%20Research%20Center%20(NPCRC))

NPCRC is committed to stimulating, developing, and funding research directed at improving care for seriously ill patients and their families.

https://documents.cthosp.org/9/aic_final_report.pdf

Report - Strategies for Change. A Collaborative Journey to Transform Advanced Illness Care
A National Quality Forum report on person-centered preferences to guide advanced illness care.

[http://www.mayoclinicproceedings.org/article/S0025-6196\(16\)30763-7/abstract](http://www.mayoclinicproceedings.org/article/S0025-6196(16)30763-7/abstract)

Report - Understanding Palliative Care and Hospice

The report, published in the Mayo Clinic Proceedings, February 2017, is intended as a review for primary providers. It defines palliative care, describes how it differs from hospice, debunks some common myths associated with hospice and palliative care, and offers suggestions on how primary care providers can integrate palliative care into their practice.