Journal Club May 2023 – Bails Et. Al SPIKES
K Butler, Summary

Spikes: A six -step protocol for delivering bad news: application to the patient with cancer
The Oncologist, 2000

Intro

1998 Annual meeting of the American society of clinical oncology symposium – surveyed 500 - 60% of respondents indicated they broke bad news from 5 to 20 times per month, 14% more than 20 times per month

- *Breaking bad news should be an important communication skill for oncologists.* I would argue the same holds true for emergency medicine providers.
- *Complex communication task, verbal component of actually giving the news, responding to the patient's emotional reactions, involving the patient in decision making, dealing with the stress created by patients' expectation for cure, the involvement of multiple family members, and the dilemma of how to give hope when the situation is bleak*

Why is breaking bad news important?

- A frequent but stressful task
    - How many times/month do you think you break bad news?
- Patients want the truth
- Ethical and legal obligations
- Clinical outcomes – psychological adjustments, extent of treatment, etc.
    - Would argue that we probably have a larger effect on the patient's initial feelings and emotions toward their prognosis than we realize, making how we paint the picture important, although difficult with often limited information

What are the barriers to breaking bad news?

- *The bearer of bad news often experiences strong emotions such as anxiety, a burden of responsibility for the news, and fear of negative evaluation, this stress creates a reluctance to deliver bad news – especially strong when the recipient of bad news is already perceived as being distressed* (I think most of the patients we deliver bad news we would likely be perceiving as already being distressed)
    - Do you all have any of these overwhelming emotions that comes before you break bad news?
- May lead to avoidance of discussing distressing information, unwarranted optimism, etc.

"The authors of several recent papers have advised that interviews about breaking bad news should include a number of key communication techniques … we have incorporated them into a step by step technique"

Six Steps of SPIKES

1) **SETTING up the interview**
    a. Arrange for some privacy
        i. This can be difficult in ED but worth it
    b. Involve significant others
        i. Q: How do we incorporate this?
    c. Sit down
        i. Eye level
        ii. Make connection with the patient
        iii. Maintaining eye contact, touching the patient's arm, patting on the back, offering a hug etc
    d. Manage time constraints and interruptions
        i. *Inform the patient of any time constraints you may have or interruptions you expect*
        ii. This is difficult in the ED setting as we often have limited time/multiple interruptions – *how many times have you been "COMM A'd" overhead during a difficult patient conversation*- Q: does anyone have ways that they set patient expectations for time available for conversation?
        iii. I think it can be helpful to inform members of your team where you are going/make them aware (I think of it similar to how we often do when we are going to do a procedure)
    e. Unless the setting is conducive, the goals of the interview may not be met.
    f. Overall I think this step is something we can focus on an lot in the ED and can be make or break to the conversation
2) **Assessing the patient's PERCEPTION**
    a. "*Before you tell, ask" – "What have you been told about your medical situation thus far… What is your understanding of the reasons we did the MRI?"*
    b. I find this one especially helpful when breaking bad news to a family member over the phone i.e., death of a loved one – sometimes they may not even know they are in the hospital or anything is wrong –
    c. Just very helpful to know how to tailor your conversation to start with this in all scenarios and avoid major misunderstandings
3) **Obtaining the patient's INVITATION**
    a. They talk about statements such as "How would you like me to give the information about the results.. would you like me to give you all the information or sketch out the results and spend more time discussing the treatment plan..?
    b. I think this one is generally more difficult to apply in the ED setting. I believe that most of our patients are expecting to know the results of their testing done in the ED. We do not necessarily have the luxury of being able to set specific remote times/places/settings to discuss results
    c. Any thoughts on this? Are there ways that you feel like you incorporate this step into your practice?
4) **Giving KNOWLEDGE and information to the patient**
    a. *Warning the patient that bad news is coming*

b. "*Unfortunately I've got some bad news to tell you… I'm sorry to tell you that…"*
c. Start at level of comprehension and vocabulary of the patient, try to use nontechnical works
d. Avoid excessive bluntness
e. Given information in small chunks and check periodically as to the patient's understanding
    i. Find it very useful to pause after each sentence or phrase – silence is not a bad thing and becoming comfortable with it I think it is very important for us
f. Avoid using phrases such as "there is nothing more we can do for you"

5) Addressing the patient's EMOTIONS with empathic responses

a. Observe for any emotion on the part of the patient
b. Identify the emotion and name it to yourself, use open questions to query the patient if unsure
c. Identify the reason for the emotion, ask the patient is unsure
d. After you have given the patient time to express their feelings, make a connecting statement
    i. "I know this isn't what you wanted to hear. I wish the news was better"
    ii. They break it down into empathetic, exploratory, and validating responses
    iii. Empathic – I can see this is upsetting to you
    iv. Exploratory – Could you explain what you mean
    v. Validating – I can understand how you felt that way
e. They state that "*Unless an emotion is cleared, it will be difficult to go on to discuss other issues. If the emotion does not diminish shortly, it is helpful to continue to make emphatic responses until the patient becomes calm. Clinicians can also use emphatic response to acknowledge their own sadness or other emotions."*
f. Q: Does anyone have specific phrases they use to address the patient's emotions? Strategies for when you are unable to "clear" the emotion?

6) STRATEGY and SUMMARY

a. Mainly focus on presenting treatment plans here, asking the patient if they are "ready for such a discussion"
b. I think this is one we certainly need to modify in the ED – would apply it to discussing follow up too.
    i. Important to have a good sense of how we are going to set the patient up for follow up etc. in outpatient diagnoses such as recurrence of malignancy etc. going in (ie, I have called VOA, urology, other SS in situations – helpful to the patient to have a clear next step and know that subspecialty providers are on the board/in the know on the diagnoses)
    ii. For inpatient diagnoses, difficult as we may not have all the details of the treatment plan but I think it helpful to give the patient's somewhat of an anticipated course when able, judge how much information they want to have about the treatment regimen

iii. “What other questions do you have for me” can be more inviting than “Do you have any other questions” but important to ensure all questions are really answered to the best of your ability before leaving the room

Does this still hold up?

How do we modify/adjust in the ED setting?

- *As the messenger of bad news, one should expect to have negative feelings and to feel frustration or responsibility.* – Breaking bad news well is not only important to the patient’s well being but also important to ours.