

CLINICAL COMMUNICATION SKILLS THEME

STAGE/LEVEL 1: 2011-2012

BREAKING BAD NEWS



FACILITATORS' PACK V.8 (14/09/2011)

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BREAKING BAD NEWS

Format of the breaking bad news session:

This is a 3 ½ hour session and will run from 14:00 – 17:30.

The group will be divided into sub-groups of six to seven students. Each 3 ½ hour session will be facilitated by one CCS facilitator per subgroup.

Please note that student packs now contain the following information:

Facilitators have been asked to adhere to strict timekeeping for all CCS sessions. Therefore, you can expect this session to start and finish on time. Please ensure that you arrive at least 5 minutes before the start of the session as students arriving after the initial group introductions may not be allowed to join the group.

Verbal feedback is provided to individual students throughout the session. Students wanting to discuss/request further feedback may wish to speak to the facilitator privately. Similarly, if the facilitator has additional feedback for individuals they may request a meeting at the end of the session. Facilitators will aim to finish with ten minutes to spare to allow time for this and student evaluation/feedback.

Recording equipment will be used in these sessions

Rationale – why is BBN important to study?

This seminar is an opportunity to make a start in considering the issues and learning the skills necessary for the vital task of breaking bad news. While students are definitely not expected to break bad news to patients themselves, they will observe many occasions where other doctors perform this task during their course and it is important that they have developed a framework to help them reflect on what they see, whether good or bad. In fact, research within the GP unit has shown that in reality many students do perceive that they have had to break bad news themselves at some point in the curriculum, despite our intentions. In their FY posts, 80% will have initiated the breaking of bad news to a patient at least once, whilst 93% will have had patients initiate discussions of bad news by asking them questions. 96% will have broken bad news to relatives of a patient. (Schildmann et al 2005, Palliative Medicine; 19: 2, 93-98)

A stressful task:

Nearly all of us will, at some time in our lives, receive bad news. As receivers of bad news we will expect the giver of the news to be skilled in the task and sensitive to our particular needs. All doctors will break bad news as a part of their normal working life. Despite familiarity with the task most doctors never become comfortable in this stressful situation. Breaking bad news can be particularly stressful when the clinician is inexperienced, the patient is young, or there are limited prospects for successful treatment.

Patients want the truth:

By the late 1970s most physicians were open about telling cancer patients their diagnosis. However, studies began to indicate that patients also desired additional information. For example, a survey published in 1982 of 1,251 Americans indicated that 96% wished to be told if they had a diagnosis of cancer, but also that 85% wished, in cases of a grave prognosis, to be given a realistic estimate of how long they had to live. Over many years a number of studies in the United States have supported these findings, although patient expectations have not always been met. European patients' wishes have been found to be similar to those of American patients. For example, a study of 250 patients at an oncology centre in Scotland showed that 91% and 94% of patients, respectively, wanted to know the chances of cure for their cancer and the side effects of therapy.

Ethical and legal imperatives:

Principles of informed consent, patient autonomy and case law have created clear ethical and legal obligations to provide patients with as much information as they desire about their illness and its treatment. Physicians may not withhold medical information even if they suspect it will have a negative effect on the patient. Yet a mandate to disclose the truth, without regard or concern for the sensitivity with which it is done or the obligation to support the patients and assist them in decision-making, can result in the patients being as upset as if they were lied to. As has been aptly suggested, the practice of deception cannot instantly be remedied by a new routine of insensitive truth telling.

Clinical outcomes:

How bad news is discussed can affect patients':

- anxiety during the consultation
- comprehension of information
- satisfaction with medical care
- level of hopefulness
- subsequent psychological adjustment (anxiety and depression)

Physicians who find it difficult to give bad news may subject patients to harsh treatments beyond the point where treatment may be expected to be helpful. The idea that receiving unfavourable medical information will invariably cause psychological harm is unsubstantiated. Many patients desire accurate information to assist them in making important quality-of-life decisions. However, others who find it too threatening may employ forms of denial, shunning or minimizing the significance of the information, while still participating in treatment.

(Baille et al 2000 The Oncologist; 5:302-311)

"I think as doctors we hate breaking bad news - we often wrap it up in such a way that it doesn't seem bad. We even sometimes conceal things from people because we don't want to upset them - but whilst well meaning this policy often creates more problems than it solves. Seriously ill patients and their families need the truth, they need to be told what is going on in language they can understand and they need our emotional support they need us to be close while they react to what we are telling them. They need several bites of the cherry...."

Murray Parkes

Session aims:

- To introduce an area of difficulty for all doctors
- To explore the reasons for the difficulties and look at ways of dealing with them
- To show that bad news is more than just dealing with fatal illness
- To establish the basic principles of good practice
- To enable students to develop a framework with which to observe other doctors break bad news
- To build on the CCS skills learnt in the Introductory Course

Special care in facilitation in this breaking bad news session:

Facilitators should acknowledge that learners may get upset in this session if for instance they have had a recent bereavement, and it may at times be necessary to give permission for individuals not to take part in some of the afternoon.

Facilitators need to be prepared for these eventualities and to use student upset positively to explore why this subject is truly so difficult. It is important for facilitators to be available for individual students if needed after sessions.

When facilitating the session please take time to consider how best to meet the possible emotional needs of the participants. Take care to ensure that learners are not pressurised to contribute or respond in a way that makes them feel uncomfortable.

Breaking Bad News please note changes to timing and set up of role plays.

Introductions:	10 mins
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- Welcome, introduce yourself, explain how this session fits in with students' overall CCS learning
- Outline a plan for the session, provided on overhead
- Brief explanation of importance of BBN (see earlier) with overhead
- Explain the aims and signpost methods of the session
- Introductions as a round (including a check to see if anyone will find this particularly hard for any reason and an offer for them to speak to the leader privately and possibly miss out on the actor session – e.g. recent bereavement etc.)

2:10 p.m. Exercise 1:	15 mins
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Exercise asking the group to describe incidents they have observed where news was broken well or badly. May be necessary to widen out scope of what Bad News is – e.g. not just fatal illness may be broken limb in a sportsperson about to compete in important tournament. Encourage them to describe skills/behaviours that seemed helpful/unhelpful. Facilitator to develop flip chart and ask information relevant to:

- the environment
- what is said
- how it is said.

Then to fill in any gaps by asking “if you had bad news broken to you what else would be important”?

Then hand out framework, discuss and ask them to watch Frasier video and think about what is/isn't addressed.

2:25 Role plays	35 mins
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Introduce the short version of the skills here (Key Skills overhead) and keep the overhead up during the session for them to consult.

See the end of this document for details of roles

It is vital we set up the role plays carefully.

Ask the group why do they think we use role play in this session when we don't normally?

Explain the purpose of the role play.

It is useful practice and an opportunity to familiarise yourself with the breaking bad news framework before working with the simulated patient. Also it can be a powerful way of experiencing the discomfort experienced by both patient and doctor in a breaking bad news situation which is an important feeling to be aware of when either involved or observing a breaking bad news situation. It also gives an opportunity to try out the framework before working with the simulated patient.

Set up melanoma role play

Divide group in two – one group are the doctors and one the patients (explain they will switch for the 2nd run through. Ask the Doctors to leave the room and give the patients their brief. Get them to think themselves into the role and talk about how they might respond if given the news in this situation. Number the patients 1-3 then ask the patients to leave the room and get the doctors back in.

Give the doctors their scenario and allow opportunity to ask questions about the case or anything else. Number the doctors and then call the patients back into the room. Ask the

doctors to find their matching number (numbering avoids them working with their friends and will hopefully help engagement).

Spend 10 minutes in role play and 5 minutes max discussing in pairs. Then get the students to begin to think of other approaches strategies that they could try out. Then second role play about melanoma – swap partners and play as before trying out different approaches.

See the end of this document for details of roles

5 minutes in plenary discussion

Difficulties – often the issue about prognosis comes up did they reveal the devastating prognosis – if they did how did they approach this and if not why not. If not already discussed explore the difference between sudden and planned BBN.

Please ask students to be back ready to start promptly at 3:20

Tea 3:00 p.m. to 3:20 p.m.

20 mins

Actors 3:20p.m. to 5:20 p.m

120 mins

This is a 2 hours session divided into three 40 minutes slots – actors rotate around the three groups with different scenarios. There are no breaks. Very accurate timekeeping is essential here to enable actors to rotate. All students should have the opportunity to practise. With six students per group, two students will be able to interact with each actor and obtain feedback.

For each actor

Get started as soon as possible to maximally use the actor

Ending 5: 20 p.m

10 mins

Brief round of how the students are feeling and what they have learnt

Facilitator to identify one strength and one area for further development for each student

Link explicitly to the CCS “explanation and planning” skills at this point (overhead to show parallels and how the skills are used in this specific situation)

Then hand out feedback forms.

For each actor

Get started as soon as possible to maximally use the actor

See the end of this document for details of student and actor roles

Facilitator to:

- describe the specific scenario in enough detail to orientate the group (setting, information already known etc.)
- specifically explain who the learners are and what their role is in the scenario (i.e. what grade of doctor and where they are practising)
- get the group to explore what the difficulties might be for the doctor and patient first

Encourage one of the students to start the process:

- What would you like to practise and refine and get feedback on
- How can the group help you best – what can they look out for

Emphasise to the “doctor” that OK to stop and start whenever. Take time out or start again as required. Re-play a section or re-play the whole lot, or just stop when help needed.

Feedback

- Start with the learner –
 - how do you feel, how did it go?
 - how do you feel in general about the role-play in relation to your objectives?
 - what went well, specifically in relation to the objectives that you defined?
 - what went less well in relation to your specific objectives?
 - or "you obviously have a clear idea of what you would like to try."
 - would you like to have another go?
- Then get descriptive feedback from the group
- If participants make suggestions, ask prime learner if they would like to try this out or if they would like the other group member to have a go. Try to get someone else to role-play a section if they make a suggestion for doing it differently. "Would anyone else like to practise?"
- Bring in the actor for insights and further rehearsal: ask actor in role questions that the group has honed down

Remember to:

- use recordings selectively
- look at the micro-skills of communication and the exact words used
- practise and rehearse new techniques after suggestions from the group
- make sure to balance positive and negative feedback
- utilise actor feedback

Session Overhead:

**Consensus recommendations for breaking bad news
Ptacek, and Eberhardt, JAMA Aug 14 1996 Vol 276, No. 6**

Physical and social setting

Location

Quiet, comfortable, private

Structure

Convenient time, no interruptions, enough time available to ensure no rushing

In person, face to face, make eye contact, sit close to patient, avoid physical barriers

People

Support network: identify and have available at patient's request

The message

What is said

Find out what patient already knows

Preparation: give a warning shot

Convey some measure of hope

Acknowledge and explore patients reaction and allow for emotional expression

Allow for questions

Summarise the discussion: verbally and or in written form, audio tape consultation.

How it is said

Emotional manner: warmth, caring, empathy, respect

Language: simple careful word choice, direct, no euphemisms or technical diagnostic terminology, avoid medical jargon.

Give the news at the person's pace, allow them to dictate what they are told

Key Steps in Breaking Bad News

1. Check what the patient already knows
2. Find out how much the patient wants to know
3. Prepare the patient: give a warning shot
4. Give the news in a step-wise manner to enable you to continuously monitor the answer to 1 and 2 and the reaction (5)
5. Allow time for reaction
6. Allow the patient's emotions to be expressed
7. Be prepared to repeat and clarify
8. Give a clear plan for the next steps of care
9. Arrange further contact

Cambridge University Hospitals NHS Foundation Trust

Breaking Bad/Significant News Guideline 2007

Reason for development

- a result of proactive risk management
- a result of patient feedback
- compliance with clinical audit recommendations
- to standardise/improve patient care

Scope

Trust Wide

Aim

To ensure that breaking of bad or significant news is imparted in an appropriate environment, is well structured, with appropriate support & in a sensitive manner

Introduction

Breaking bad or significant news is a common occurrence in all areas of the Trust.

How news is discussed can affect an individual's anxiety, comprehension of the information, satisfaction with care, level of hopefulness & subsequent psychological adjustment.

This document outlines recommendations for breaking bad news in a way that would ensure that the standard is achieved.

Ideally breaking bad or significant news should be undertaken by a senior doctor or nurse, i.e. not PRHO or staff nurse

It is recommended that if you are breaking bad news regularly you should have undergone communication skills training as part of CPD.

Recommendations

4.1 Preparation & Environment

- Location should be comfortable, private & quiet
- Convenient time
- Where possible the discussion should be planned & provision made to ensure there are no interruptions
- The news should be given, whenever possible, face to face, i.e. not over the telephone
- Ideally physical barriers such as desks should be avoided.
- Ensure that you have all the appropriate information you require, i.e. test results etc
- Identify member of the clinical team who is able to offer support at the time & afterwards should it be required i.e. specialist nurse

4.2 The people involved

- Identify & have present at the patient's request appropriate significant other
- Ideally there should be minimal clinical staff present i.e. doctor & nurse only, unless agreed with the individual

4.3 Breaking the News

4.3.1 What is said

- Find out what the person already knows and obtain a sense of how they are feeling
- Preparation: give a warning signal
- Break the news
- Acknowledge & explore the individual's reactions & feelings
- Allow for questions, answer openly & honestly
- Check understanding, repeat & clarify as required
- Summarize the discussion, verbally & in writing
- Offer a plan of action, confirm immediate next steps
- Provide as much positive practical support, but not false reassurance
- Convey some measure of hope tempered with realism

4.3.2 How it is said

- Emotional manner (warmth, caring, supportive, respectful)
- Use appropriate non-verbal communication
- Use simple & careful language without euphemisms and avoiding jargon
- Give the news at the individual's pace, allowing time for reaction
- Give information in chunks, checking repeatedly for understanding and feelings
- Read and respond to patient's non-verbal cues
- Encourage expression of feelings
- Demonstrate empathy by acknowledging patient's reactions and feelings

5.0 Evidence

Referral for Suspected Cancer. A Clinical Practice Guideline.
National Institute for Clinical Excellence. June 2005

Consensus recommendations for breaking bad news
Ptacket & Eberhardt. JAMA Aug 14 1996. Vol 276, No. 6

Guidance from Susie Wilkinson, National Lead for Advance Communication Skills Training program

Kurtz SM, Silverman, JD, Draper, J (2005) Teaching & Learning Communication skills in Medicine
2nd Edition. Radcliffe Publishing, Oxford.

Silverman, JD, Kurtz, SM., Draper, J., (2005) Skills for Communicating with patients 2nd Edition.
Radcliffe Publishing, Oxford

WACN Breaking Bad News Audit Report 2003/4

SUMMARY OF SUGGESTIONS FOR BREAKING BAD NEWS

Preparation:

- if planned set up appointment as soon as possible
- allow enough uninterrupted time; ensure no interruptions
- use a comfortable, familiar and ideally private and quiet environment
- avoid physical barriers (such as desks)
- encourage patient to invite spouse, relative, friend, as appropriate
- be adequately prepared re clinical situation, records, test results and patient's background
- put aside your own "baggage" and personal feelings wherever possible
- think through what you want to say
- identify a member of the clinical team who can offer support either at the time or afterwards if required

Beginning the session / setting the scene

- summarise where things have got to, check with the patient
- discover what has happened since last seen
- calibrate how the patient is thinking/feeling
- negotiate agenda

Sharing the information

- assess the patient's understanding first: what the patient already knows, is thinking or has been told
- gauge how much the patient wishes to know
- give a warning first that difficult information is coming e.g. "I'm afraid we have some work to do..." "I'm afraid it looks more serious than we had hoped..."
- give basic information, simply and honestly; beware of qualifiers we use to try and make the news easier for us to deliver "the cancers spread, **a little**"
- check understanding and repeat and clarify important points as required
- relate your explanation to the patient's perspective
- do not give too much information too early; don't pussyfoot but do not overwhelm
- give information in small "chunks"; verbally categorise information "there are three important points we need to discuss"
- avoid jargon
- allow for questions
- **watch the pace, check repeatedly for understanding and feelings as you proceed**
- use language carefully with regard given to the patient's intelligence, reactions, emotions: avoid jargon
- be aware of your own nonverbal behaviour throughout

Being sensitive to the patient

- read and respond to the patient's non-verbal cues ; face/body language, silences, tears
- allow for "shut down" (when patient turns off and stops listening) and then give time and space: allow possible denial
- keep pausing to give patient opportunity to ask questions

- gauge patient's need for further information as you go and give more information as requested, i.e. listen to the patient's wishes as patients vary greatly and one individual's preferences may vary over time or from one situation to another
- encourage expression of feelings early, i.e. "how does that news leave you feeling", "I'm sorry that was difficult for you", "you seem upset by that"
- respond to patient's feelings and predicament with acceptance, empathy and concern "that's difficult news to take",
- check patient's previous knowledge about information just given
- specifically elicit all the patient's concerns
- check understanding of information given ("would you like to run through what are you going to tell your wife?")
- be aware of unshared meanings (i.e. what cancer means for the patient compared with what it means for the physician)
- do not be afraid to show emotion or distress

Planning and support

- having identified all the patient's specific concerns, offer specific help by breaking down overwhelming feelings into manageable concerns, prioritising and distinguishing the fixable from the unfixable
- identify a plan for what is to happen next
- give a broad time frame for what may lie ahead
- offer practical support
- give hope tempered with realism ("we can no longer stop the cancer spreading but there are lots of other things we can do to treat your symptoms")
- ally yourself with the patient ("we can work on this together ...between us"), i.e., emphasise partnership with the patient, confirm your role as advocate of the patient
- emphasise quality of life
- safety net

Follow up and closing

- summarise and check with patient for understanding, additional questions
- don't rush the patient to treatment
- set up early further appointment, offer telephone calls, etc.
- identify support systems; involve relatives and friends
- offer to see/tell spouse or others
- make written materials available

If the patient attends with a companion, read and respond to the companion's verbal and non-verbal cues, and allow pauses for questions, but remember that the patient is your first concern

Throughout be aware of your own anxieties - re giving information, previous experience, failure to cure or help

Kurtz SM, Silverman JD, Draper J (2005) *Teaching and Learning Communication Skills in Medicine 2nd Edition*. Radcliffe Publishing (Oxford)

Silverman JD, Kurtz SM, Draper J (2005) *Skills for Communicating with Patients 2nd Edition*. Radcliffe Publishing

Session Laminates:

Role for Students to play

Patient

You are a student of your own age and sex. Two weeks ago you attended the dermatology out-patient clinic for the removal of a mole on your thigh. The doctor who did the operation was cheerful and confident that there was nothing to worry about. You have returned to the clinic for a routine check on wound healing and you expect to be discharged with a clean bill of health.

You are aware that some moles can be malignant and that in some cases this can be very serious indeed. You know of someone from your old school that is very ill with malignant melanoma and seems to be constantly in and out of hospital.

As the doctor in this role play talks to you try and react to what is said in a realistic way. Consider how you might feel if this happened e.g.

Angry that you had been misled

Upset

You might react by being quiet and reflective.

Sure that some mistakes have been made.

This cannot be correct I was told I would be ok.

Practical and accepting – keen to know what should be done next to cure the problem.

You might be wondering how you will tell your friends and family.

Role for Students to play

Doctor

You are a doctor working in dermatology. Two weeks ago a mole was excised from the thigh of a local student by one of your colleagues. On clinical grounds that doctor felt reasonably certain that the histology would be benign, and asked the student to return for removal of sutures and review. You are asked to see the student, as your colleague is away at a conference.

To your surprise and consternation, the histology shows a penetrating malignant melanoma. Although completely excised, a further, wider excision will be needed and you have to explain this to the student. You will need to make an urgent referral to the plastic surgeons for this procedure. Wide excision with skin grafting and block dissection of the group glands is likely to be needed.

You know that the prognosis for malignant melanoma is related to the thickness of the lesion – thinner lesions having better prognosis. In this case the lesion is at least 3mm thick in parts, which puts it in an intermediate category with a 5-year survival below 50%.

You must judge how much information to give at this stage.

Your task is to give the information that you feel is relevant, in an appropriate manner, to the student. You will need to explain what needs to be done and to deal with the student's reaction and questions.

Information for facilitators to give to students for the three actor roles:

BBN Scenario 1 – Breast Clinic: Student Brief

The patient (Catherine Morley) is attending the breast clinic for investigations of a breast lump. She has been examined by the nurse practitioner, had a mammogram, an ultrasound scan and has had biopsies from both the breast lump and from a palpable axillary node.

You are the clinic radiologist and you have not met her before. You need to tell Mrs Morley that the diagnosis is almost certainly cancer. Confirmation via results of the biopsies will be available in a week, however, you have enough information to proceed with letting her know in clinic today that the findings are highly suggestive of Breast Cancer (you are 95% certain, the biopsy will give you a histological diagnosis). The patient will return to the clinic for an appointment with the surgeon and oncologist for discussion of treatment options, therefore you need to prepare her for this next visit.

Likely treatment options: Mrs Morley's case will be discussed at a breast MDT and a treatment recommendation formulated depending on the specific information from the biopsies. The likely initial treatment for this lady will be a Mastectomy and axillary clearance, with or without primary breast reconstruction. Additional treatment will be considered once results of surgery are available. This may include radiotherapy (15 daily treatments over a period of 3-4 weeks), chemotherapy (6-8 treatments once every three weeks) or hormonal treatment (one tablet daily for 5 years). Mrs Morley may also be offered entry to a number of clinical trials. You can decide how much of this information you wish to impart to Mrs Morley today.

www.breastcancercare.co.uk

BBN Scenario 2 – Neurology Outpatients: Student Brief

You are an SpR in Neurology, in the clinic setting. Your patient (Jo Baines) was seen by your colleague in the Neurology clinic 3 weeks ago, with a history of pain in the eyes and a slight change in colour vision. He/she has had an MRI scan, visual evoked potentials (VEP) and a lumbar puncture done recently and is re-attending clinic for the results of all these tests today. You need to break the news that the results are in keeping with a diagnosis of Multiple Sclerosis.

Multiple Sclerosis (MS) is a disease with a relapsing remitting course. It is very difficult to tell from the outset how badly someone is going to be affected. There are no predictive factors for how rapid a course will be or even for whether a patient will have further attacks.

Acute relapses are treated with high dose steroids. NICE guidance does not recommend interferon or glatiramer acetate for treatment. The course of the disease is variable but tends to follow a pattern of relapses followed by full recovery over a period of years, leading to a stage when recovery is not complete between attacks and finally an inexorable decline again usually stepwise.

www.patient.co.uk/health/Multiple-sclerosis.htm

www.mssociety.org.uk

www.mstrust.org.uk

www.patient.co.uk/health/Multiple-sclerosis.htm

BBN Scenario 3 – Emergency setting: Student Brief

You are doctor in the Emergency Care Centre. The nurse has just asked you to speak to Mr/Mrs Green - "Mr/Mrs Green is here, would you talk to him/her...?"

Their daughter Emily was found unconscious at home by her flat-mate earlier today. The flat-mate called for an ambulance to attend the scene. En route in the ambulance, Emily had a respiratory arrest and required intubation; Emily has been stabilised in the Resuscitation area and is now being ventilated. She is also in the process of being transferred to the Intensive Care Unit (ITU). There is a risk of brain damage secondary to hypoxia, or any other cause contributing to the collapse in the first place, however, the outcome is not yet clear. Therefore, at this stage, you are thinking that she could still make a full recovery/ have some hypoxic damage with resultant impairments/ or maybe not even survive if she has any further deterioration in her clinical condition.

Father/Mother has received a call from the department to say Emily has been brought in but has no information yet as to the details of today's events. The cause of the respiratory arrest is not known, therefore any background information available from Mr/Mrs Green is likely to be helpful for her medical management. You are required to break the news regarding Emily's admission and management so far, and also to ascertain background information on Emily, and any clues that could assist the ITU team in her ongoing care.

Collapse:

www.library.nhs.uk/EMERGENCY/ViewResource.aspx?resID=266672

Unconsciousness:

www.ambulancetechnicianstudy.co.uk/unconscious.html

Antidepressant medication:

www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression/antidepressants.aspx

Facilitator Information Only:

Breaking bad news – simulated patient role 1

Name: Catherine Morley

Age: 35+

Setting:

You are a 35+ year old woman. Twice married, you have two children, both girls (aged 10 and 8), from your first marriage. You also have a 4-year-old son from your second marriage. You are a primary school teacher and you plan to return to work when your 4 year old goes to school. Your 2nd husband is in work [decide what his occupation is].

Your mother died (aged 40) with breast cancer. She was already very ill before she went to the doctor and her death followed only 6 months after the diagnosis was made.

Today you are in the breast clinic expecting to hear the news that it is cancer. Although you know that surgery and drugs can be used and women do get better, you are not hopeful because you delayed so long.

History:

You first noticed a small lump in your breast 6 months ago. Since you went to the gp 10 days ago things have moved very quickly. The gp confirmed you had a lump but was reluctant to say anything about what it was but referred you to the breast clinic. You have been examined by a nurse practitioner, had a mammogram, ultrasound and biopsies of the breast lump and from a palpable axillary node. You are now about to be seen by the doctor who is a radiologist.

Your concerns:

When you first noticed a small lump in your breast (6 months ago), you felt so busy and pressurised that you did not allow yourself to worry. You kept it to yourself. Now you very much regret the delay; as your apprehension mounts, you worry that you are following your mother's footsteps. The lump has been growing and now you know, in your heart, that this must be cancer. You try to be positive and think all will be well but this is increasingly difficult.

'if it is cancer, what about my children? What are the implications for my daughters?' you feel you should never have had children! You cannot bear the idea of leaving them, but even worse is the idea that breast cancer is running in the family and they will have the same problem.

Your reaction:

You do not tell the doctor that you delayed going to your gp for so long. You don't want to be blamed. If the doctor says anything about it being good that you came quickly, you say that it was not quick at all. Making this admission is upsetting and you show this emotionally.

If the doctor is more controlling and less permissive of emotion, then you show more interest in the next steps. The more treatment the doctor mentions, the more you

begin to feel it is pointless and hopeless. You withdraw into yourself and tend to be rather monosyllabic.

If the doctor notices this and supports you in talking about your concerns, then you tell him/her about your mother. This should introduce the worry about it running in the family and again if the doctor is empathic/approachable, you mention your fears about your daughters.

Facilitator Information Only:

Breaking Bad News – simulated patient role 2

The patient is a 25 year old man or woman who has been seen for neurophysiological tests following the second episode of optic neuritis.

Mr/Mrs Joe/Jo Baines – you are 25 years old and work as a self employed swimming instructor. Your business has recently been getting off the ground and is starting to do well, but you are far from financially secure. You are married and have an 18 month old daughter. Your partner does not work because of a bad back and you are reliant on your income to pay the bills.

You went to see your GP with an episode of pain in the eyes which has now settled. You had a similar episode 5 years ago for which the GP at the time referred you to a local eye specialist who told you that you had inflammation at the back of the eye and not to worry about it but let your GP know if it happened again. You were left with a slight loss of colour vision but nothing else. About 3 weeks ago it happened again but in the other eye. Your GP seemed concerned and referred you to the neurologists who have done a number of tests including a MRI scan, taking some fluid from your back (which was painful and left you with a headache) and a test involving flashing lights into your eyes. You have come back to the clinic to get the results.

Because things have settled you are just expecting the doctors to give you a clean bill of health. You are not sure why they did so many tests and didn't bother asking too much.

You know something about multiple sclerosis because one of your friends at school had a mother with it. When you knew them she was quite disabled but able to get about with help. When you last saw her (about 10 years ago) she was confined to bed and you since heard that she had died. She would have been in her late thirties when she died.

The student acting in the role of SpR in the neurology clinic has to break the news that the findings on the scan and from the lumbar puncture confirm that the patient has multiple sclerosis.

Facilitator Information Only:

Breaking bad news – simulated patient role 3

Name: William or Betty (Beth) Green **Age:** old enough to have child in early 20s

Setting:

You received a call from Addenbrooke's A&E department to say that your daughter Emily has been brought into the hospital by ambulance and is unconscious. No other details are given. You were asked to come as soon as you can. Your spouse is out of town on business so you attend alone. The department is very busy, and it takes a little time for you to get to the reception desk where you explain who you are. The receptionist shows you into an interview room, asks you if you would like a tea or coffee and says that one of the doctors will come and talk to you as soon as possible. You are frantic with worry, but she is unable to give you any information at all. You wait on your own, sipping a cup of coffee, getting more and more concerned.

A young house officer enters.

Clinical details:

Emily has taken a serious overdose of thedothiepin (tricyclic antidepressant) tablets prescribed for her depression by her gp. She was found that morning by a flatmate, unconscious and blue, having inhaled vomit. She had a respiratory arrest in the ambulance and had to be ventilated by the paramedics all the way to the hospital. She is unconscious and the doctors are very concerned about the possibility of brain damage. There is also the possibility of heart damage from the drug itself. The delay in the doctor seeing you is because Emily has had to be put on a ventilator and is being closely monitored. Results of blood tests, drug levels and so on are awaited. Emily is currently in a very serious but stable condition. She may die. She may survive unscathed or she may survive with more, or less, brain damage. Only time will tell at this stage.

Family background:

Emily is an only child. She had always been a difficult child with mood swings, some suggestion of an eating disorder in her early teens and a number of previous less serious drug overdoses. You and your partner are busy professional people who have tried your best to support her but actually found it something of a relief when she moved out of the parental home to share a flat with a friend. She has only ever held down poorly-paid temporary jobs in spite of having good A levels. You have continued to support her financially when the need arises – which is quite often.

- Family history: no family history of mental illness – tend to regard mental illness as lack of 'moral fibre' – mixed emotions of concern for Emily's difficulties and some shame about it.
- Social history: both parents university educated, well informed. Run own computer software development company – both systems analysts.
- Temperament: analytical, concerned in a hands-off sort of way. Sheltered background not much exposed to nor very tolerant of other people's weaknesses.

Relative's framework:

Ideas: Emily's overdoses are becoming a serious problem – some feeling that she is using them as a weapon to hurt people, not just herself. Couldn't have timed this one worse – called away from an important business meeting – on point of landing a large contract.

Expectations: confused – something's got to be done about Emily. We can't cope any longer. But genuinely love her and want best for her.

Feelings: very confused – concern, upset but also very angry with Emily, with others who seem to have failed in efforts to help her. Guilty about having failed her. 'where did we go wrong?' anxious about business and the image this may create.

Effect on life: fed up with everything revolving around Emily – she should be a grown-up now and she is still behaving like an immature child. Would like to have a 'normal' child, starting to be fully independent – looking forward to being grandparents in due course. Can't see this happening.

Your reaction to the news:

One purpose for this scenario is to give the students the opportunity of dealing with relatives rather than the patient and to let them experience something of the range of emotions expressed when bad news is broken. First time through it is suggested that you react with understandable upset – great concern about the seriousness of the situation, a wish to see your daughter as soon as possible, and a rush of questions along the 'she's going to be all right, isn't she?' line.

Depending on the lead given by the facilitator, you may be asked to react in a number of different ways, such as:

- Distress – tears, collapse. 'I can't believe it'. 'tell me it isn't so.'
- Anger – perhaps directed against the gp. 'why does he keep giving her more pills? They don't do any good and only stockpile them for the next overdose.' 'why didn't he give her those new antidepressants which aren't so poisonous?'
- Shock – silence – numbness. 'what have we got to do?'
- Guilt – perhaps you had a row with Emily last night, and left with bad feeling between you. Perhaps even to the extent of threatening her, or responding to her seemingly vague talk of doing herself harm again with 'well, go on then do it – and do it properly!'

Further reading:

Baile W et al 2000 SPIKES: A six-step protocol for delivering bad news: application to the patient with cancer. *Oncologist*; 5: 302-11. A practical approach to delivering bad news

Benson J & Britten N 1996. Respecting the autonomy of cancer patients when talking with their families: qualitative analysis of semistructured interviews with patients. *BMJ* 313. 729-31. The patients studied preferred the doctor to be open with the family but most rejected unconditional disclosure of information without consent and the family influencing what information they should be given.

Buckman R 2002 Communications and emotions *BMJ* 325:672 (28 September)
Meredith et al 1996. Information needs of cancer patients in West Scotland: cross sectional survey of patients' views. *BMJ* 313 724-6. Almost all patients want to know their diagnosis and most wanted to know about prognosis, treatment options and side effects.

Degner L et al 1997. Information needs and decisional preferences in women with breast cancer. *JAMA* 277. 1485-92 There is a substantial discrepancy between women's preferred and attained levels of involvement in decision making

Fallowfield L Jenkins V 2004 Communicating sad, bad, and difficult news in medicine. *Lancet* 363: 312. . A brief guide suggesting how to improve the delivery of such news in non-urgent settings.

Faulkner A 1998. ABC of Palliative Care. Communication with patients, families, and other professionals *BMJ* 316 130-32

Maguire P et al 1996. Family members' attitudes toward telling the patient with Alzheimer's disease their diagnosis. *BMJ* 313. 529-30. 83/100 relatives said the patient should not be told, however, 71/100 wished to be told if they had the same diagnosis.

McLauchlan C 1990. Handling distressed relatives and breaking bad news. ABC of Major Trauma. *BMJ* 301. 1145-9. Advice from a doctor working in Accident and Emergency Medicine.

Schildmann J et al 2005, Research into PRHOs experiences of breaking bad news *Palliative Medicine*; 19: 2, 93-98.

Personal views from the literature

BMJ 1987. 295 1060. a medical student describes finding he has a mole - its initial misdiagnosis and a revised diagnosis of malignant melanoma.

BMJ 1993 307 1502. A GP describes the aftermath of insensitive breaking of bad news.

NEJM 1979 300(6) 284-8 Fighting cancer - one patients perspective. An American physician describes discovering a testicular lump.

BMJ 2002;324:1285 (25 May) Breaking Bad News – a patient describes her experience of having been told bad news

BMJ Learning Interactive Study

<http://www.bmjlearning.com/planrecord/servlet/ResourceSearchServlet?keyWord=&resourceId=5001101&viewResource=>

A self-directed resource dealing with breaking bad news