Breaking 'Bad': A Practical Guide for Communicating Bad News

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The body of work on breaking bad news in medicine is primarily based on cancer diagnoses and is associated with an alphabet soup of algorithms. Thus, there is a need for an approach that is more suited to surgical problems. This article focuses on the issues surrounding communicating bad news and bad outcomes to surgical patients, how these discussions impact care outcomes, and how orthopaedic surgeons can successfully navigate these conversation.

In orthopaedic surgery, breaking "bad news" can be a source of stress for both patients and physicians. Whether it is a difficult diagnosis, bad outcome, surgical complication, or failed treatment, communicating the findings and options with empathy remains a challenge to even the most experienced physician.

Despite a general understanding of the importance of sharing the "hard facts" about any illness or outcome, communications are plagued by issues such as medical lingo, complex statistics, and fuzzy language. Some of the lingo is designed to protect physicians from overpromising and underdelivering, which, by itself, could be interpreted by laypeople as medical malpractice. Moreover, patients are generally unsatisfied with the way physicians deliver bad news.

Why do physicians struggle with breaking bad news?

Much of the struggle lies in the balance between honesty and the physician's own personal feelings of failure. In the worst cases, hope may be all a patient has left, and therefore the potential impact of difficult news on that hope adds uncertainty to the situation. Most will agree that removing all hope leaves the patient with no option but despair. As a result, a physician may hesitate to provide all details of the bad news and ultimately may confuse the patient. Limited time and lack of communication skills training may play a role in the general fear of this important medical activity. No two communications fit an exact mold, and the uniqueness of each physician-patient dialogue adds to the complexity of the discussion. Past efforts to codify the process are summarized by several algorithms in the literature, as shown in Tables 1, 2, and 3.

Given the varying structures of these methods, it is understandable why formal education for medical school students to practice breaking bad news to patients is limited and not standardized. Some medical schools utilize standardized patients, or individuals trained to act as patients in mock scenarios for medical diagnoses and physical exams. However, these interactions are rarely used for delivering bad news. Those skills are often left to residency-level training through actual patient encounters.

The language of bad news

Perhaps the most important component in effectively delivering bad news is the emphasis on language. Understanding the patient's reading level, using common nontechnical language, and having an additional person in the room, if the patient permits, can help overcome language issues in difficult conversations.

Another important component of breaking bad news is the "teach-back method," in which the physician assesses patient understanding by asking the patient to state in his or her own words what has been explained. Simple changes in language can also facilitate conversation. In the physician-patient relationship, the physician has expertise that can be intimidating to the patient. Physicians may not understand how their language can limit questioning

The SPIKES protocol

S: Set up the interview.
P: Assess patient's perception.
I: Obtain the patient's invitation.
K: Give knowledge or information to the patient.
E: Address the patient's emotions with empathetic responses.
S: strategy and summary

This method was developed originally in 2000 in the context of oncology. Since then, it has been adopted more widely. Some limitations of the SPIKES approach are that it does not assess for patient questions or for patient understanding. An additional limitation is that the SPIKES approach is based on expert opinion and is not evidence-based.

Table 1. The six-step protocol for delivering bad news

SOURCE: BAILE WF, BUCKMAN R, LENZI R, ET AL: SPIKES—A SIX-STEP PROTOCOL FOR DELIVERING BAD NEWS: APPLICATION TO THE PATIENT WITH CANCER. *ONCOLOGIST*. 2000;5(4):302-11.

S-P-w-ICE-S

S: setting
P: perception to identify gaps
w: warning call and pause
ICE: ongoing juggling between providing information, clarifying, and dealing with emotions
S: Share possible strategy, summarize, and support.

This method adds to the success of SPIKES by including opportunity for clarification and further empathy. The authors of the S-P-w-ICE-S approach based their protocol on an additional 12 tips, which may be too lengthy and complex for practical use in the typical healthcare setting. Although the S-P-w-ICE-S approach does note eliciting "clarification questions" from patients, it does not include elements of active retrieval or assessment of patient understanding.

Table 2. Twelve tips for breaking bad news

SOURCE: MEITAR D, KARNIELI-MILLER O. TWELVE TIPS TO MANAGE A BREAKING BAD NEWS PROCESS: USING S-P-W-ICE-S—A REVISED VERSION OF THE SPIKES PROTOCOL. *MED TEACH*. 2021 MAY 30:1-5 [EPUB AHEAD OF PRINT].

ABCDE

A: advanced preparation
B: Build a therapeutic environment/ relationship.
C: Communicate well.
D: Deal with family and patient reactions.
E: Encourage and validate emotions.

This approach has an easy-to-remember acronym and provides many of the elements important when breaking bad news. This method does not specifically mention the physician providing a summary or discussing follow-up. There is no call to action to resolve the problem at hand. Therefore, these important components are not in the conversation. When the problem is a surgical situation, it is missing possible hope for the patient and alternative solutions. Leaving this part out, it falls short as a practical tool in orthopaedics.

Table 3: The ABCDE system of going beyond breaking bad news

SOURCE: RABOW MW, MCPHEE SJ: BEYOND BREAKING BAD NEWS: HOW TO HELP PATIENTS WHO SUFFER. *WEST J MED*. 1999;171(4):260-3.

PARSEC

P: Prepare treatment options based on the patient and diagnosis.
A: Give your full undistracted attention by providing adequate time and being in a quiet and appropriate setting, all important to best convey bad news.
R: reassurance of support and/or medical options, such as bringing significant others/family members into the process when needed to help in hearing the news, asking questions, and recalling the important elements of the possible next steps
S: Seek an understanding of patient preferences.
E: Set expectations for the discussion and delivery of the news
C: Create a safe and supportive opportunity for questions.

Table 4: PARSEC: Six practical steps of breaking bad news for surgical practice. The authors' proposed, simplified approach to breaking bad news in surgical situations

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and is intimidating to less medically educated patients. Asking "Do you understand?" invites a nod, even though the patient may not understand. Alternatively, asking the open question "What questions do you have?" instead of "Do you have any questions?" may facilitate clarification, give much needed room for questions, and be far less intimidating.

Orthopaedic considerations

In the literature, "bad news" is usually defined as a new diagnosis of cancer. In orthopaedic surgery, bad news is more focused on general quality-of-life issues and potentially life-altering injuries. How does an orthopaedic surgeon tell a star athlete that an injury is season-ending? How does one tell a working adult that an injury is potentially career-ending? How does a surgeon tell a trauma patient that he or she may lose a limb? How does one address surgical complications that limit the potential outcome of the best planned surgery? How does one discuss an infected total joint replacement that has to be removed, or propose a revision surgery for recurring dislocations? How does a surgeon tell a patient that he or she is not a surgical candidate or, worse, that there is very little to offer for an orthopaedic problem? When reviewed, most of the current guidelines for difficult discussions are less applicable for the specific issues outlined above.

Four components of breaking bad news

Breaking bad news comes down to four major components:

- understanding patient preferences
- setting expectations
- providing opportunity for questions
- giving reassurance of physician support, including possible medical treatment options

Giving full attention, providing adequate time, and being in a quiet and appropriate setting are all important considerations for conveying bad news. Additionally, bringing a significant other into the process can help a patient to hear the news, ask questions, and recall the important elements of the next step. There is nothing more discouraging to a caring physician than learning that a patient did not have the ability to digest what was said because he or she could not recall any details or concentrate after the first bit of the news was delivered. It is vital for the patient to have a friend or family member who can provide reassurance and reinforce that the physician will support the patient.

> *Whether it is a difficult diagnosis, bad outcome, surgical complication, or failed treatment, communicating the findings and options with empathy remains a challenge to even the most experienced physician.*

If physicians prepare options, give their full attention to the conversation, provide reassurance, seek a level of understanding, set expectations for the conversation, and create a safe way to ask questions, they can turn bad news in to an opportunity for personalized treatment. This new, action-based approach, called PARSEC, is summarized in Table 4.

If the patient's perspective on bad news is better understood, the conversation leaves the patient satisfied and creates a better perception about his or her healthcare. Including the patient in the conversation also provides an important opportunity for shared decision-making. Moreover, understanding the complexity of breaking bad news helps physicians simplify the approach. There is good reason for teaching and learning the art of breaking bad news in medicine in general and orthopaedics specifically. It is a required lifelong skill that warrants training and practice during medical school, residency, and beyond.

References for the information cited can be found in the online version of the article, available at www.aaosnow.org.

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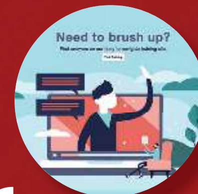

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