Breaking Bad News Better: Communication Skills for the Oncology Professional

ABBY FUOTO DNP, ANP-BC, AOCNP, ACHPN

THE ARIZONA CLINICAL ONCOLOGY SOCIETY MEETING

APRIL 13, 2024

Faculty

Abby Fuoto DNP, ANP-BC, AOCNP, ACHPN
Nurse Practitioner & Specialty Instructor
Division of Geriatrics, General Internal Medicine, and Palliative Medicine
Department of Medicine
University of Arizona College of Medicine
Banner University Medical Center – Tucson

Disclosures

Abby Fuoto, DNP, ANP-BC, AOCNP, ACHPN discloses no relevant financial relationships with any entity producing, marketing, re-selling, or distributing healthcare goods or services consumed by, or used on, patients during the past 24 months.

Learning Objectives

1. Recognize the psychological impact of breaking bad news on the oncology provider and the patient
2. Identify three different communication strategies, the “SPIKES” model, Serious Illness Conversation Guide, and Best Case/Worst Case/Most Likely Case Scenarios, when breaking bad news
3. Apply communication skills for breaking bad news using real life patient case scenario

The impact of Breaking Bad News

Most providers find giving bad news uncomfortable

- Minimal training
- Time burden
- “I don’t want them to lose hope”

However, everyone will need to give bad news

- Differing views within interdisciplinary team regarding prognosis and what to disclose

Breaking bad news in the wrong way can impact patients and caregivers

- Increased distress
- Decreased compliance

Why does this matter?

High rates of moral distress and burn out amongst oncology professionals

When done well, a difficult discussion can

- Foster trust and facilitate understanding
- Help patients and caregivers feel heard
- Allow an exploration of what matters most
- Improve collegiality within interdisciplinary team

“They just don’t get it”

There is a lot of uncertainty in oncologic prognostication

- Accuracy in prediction models ranges between 23-78%

Many patients and caregivers have unrealistic expectations about

- Long term prognosis
- Functional status
- Caregiving support needs over time
- 69% of patients with metastatic lung cancer and 81 % of patients with metastatic colorectal cancer thought they could be cured

Common missteps we all make at some point

Starting with information

Using too much jargon

Talking too fast

Standing up

Speaking to the wrong person

Not answering the questions

Answering emotional questions with a logical answer

Giving options without offering a recommendation

Where do we go from here?

Models for Breaking Bad News

SPIKES protocol

Serious Illness Conversation Guide

Best-Case/Worst Case/Most Likely Case Scenarios

And many, many more

- COMFORT
- ABCDE
- PEWTER

SPIKES

SPIKES

Setting up

Perception

Invitation

Knowledge

Emotions

Summary

Setting Up

Confirm medical facts

Plan what to say

Create a conducive environment

Find out if patient wants others present

- in person or by telephone

Perception

Before you tell, ask what the patient/family knows

Explore the patient's knowledge, expectations

Assess ability to comprehend bad news

- If patient lacks capacity, reschedule when family can be present

Invitation

Ask what the patient wants to know and how much detail

Recognize and support patient preferences

Give patient control over hearing the news

Knowledge

Foreshadow and then share the news

Say it clearly

Avoid jargon

Avoid excessive bluntness

- But don’t minimize severity

Pause frequently to check for understanding

Emotions

Respond to emotion with empathy

Give time for patient to react

Listen, use non-verbal communication

Encourage descriptions of feelings

Explore and clarify concerns and fears

Summary

Reiterate next steps

Document discussion clearly

Update other team members

Serious Illness Conversation Guide

Serious Illness Conversation Guide

Set up the conversation

Assess understanding and preferences

Share prognosis

Explore key topics

Close the conversation

Document your conversation

Communicate with key clinicians

Set up the conversation

Introduce the purpose

Prepare for future decisions

Ask permission

“I would like to talk together about what’s happening with your health and what matters to you. Would this be ok?”

Assess understanding and preferences

“To make sure I share information that’s helpful to you, can you tell me your understanding of what’s happening with your health right now?”

“How much information about what might be ahead with your health would be helpful to discuss today?”

Share prognosis

Frame as a **“wish…worry”** or **“hope…worry”** statement

Allow silence

Explore emotion

“Can I share my understanding of what may be ahead with your health?”

“I wish this was not the case. I am worried that time may be as short as _____.”

- express as a range, eg days to weeks

“It can be difficult to predict what will happen. I hope you feel as well as possible for a long time, and we will work toward that goal. It’s also possible that it may get harder to do things because of your illness, and I think it is important that we prepare for that.”

Explore key topics

“If your health was to get worse, what are your most important goals?”

“What are your biggest worries?”

“What activities bring joy and meaning to your life?”

“If your illness was to get worse, how much would you be willing to go through for the possibility of more time?”

“How much do the people closest to you know about your priorities and wishes for your care?”

“Having talked about all this, what are your hopes for your health?”

Close the conversation

“I’m hearing you say that ___ is important to you and that you are hoping for ___. Keeping that in mind, and what we know about your illness, I recommend that we ___. This will help us make sure that your care reflects what’s important to you. How does that plan sound to you?”

“I will do everything I can to support you through this and to make sure you get the best care possible.”

Document and Communicate

Document your conversation

- ACP tab in EMR
- Label discussion as “Goals of Care”

Communicate with key clinicians

- cc providers on your note
- Send them a direct message
- Include your interdisciplinary team

Best Case
Worst Case
Most Likely Case

Best Case

"I have bad news. You have _____ and we need to talk about what to do."

"We have a choice between two options."

"In the best case…"

- Realistic best long-term outcome
  - "I think your mom will eventually get home, but weaker and needing more assistance"
- Short-term implications: tell a story about what treatment and recovery entail, e.g., hospital course, SNF
  - "To get her there, we will need to do a big surgery, she will be in the ICU for 2-4 days, then in the hospital for another week, then rehab for 1-2 months"
- Orient into context of patient's overall health and prognosis
  - "…still needs oxygen for her COPD."

Worst Case

"In the worst case…"

- Include the reasonable worst long-term outcome
- Describe what happens between now and the worst long-term outcome
- When death is possible, avoid euphemisms, e.g., say "die" rather than "pass away".
  - For most patients, death in the operating room is not typically viewed as the worst outcome.
  - Often, death in the ICU after weeks of complications is considered worse.

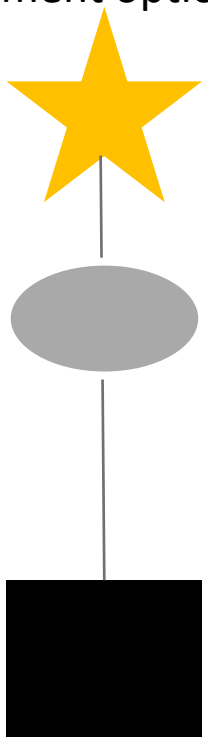
Most Likely Case

"Based on what I know about you, what I think is most likely…"

- Circle a point on the line representing where the most likely outcome falls between best and worst case
- Try to avoid using percentages and numbers, instead interpret that information to describe for patients what it means (e.g., "you will be dependent for care and will not likely walk again")
- There might not be any outcome between best and worst case, this should be acknowledged, note which is more likely (best or worst case) and acknowledge the possibility that the other could occur

Map it out

Treatment option 1

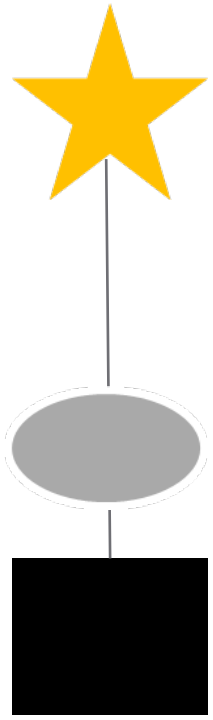


Best Case

Most Likely

Worst Case

Treatment option 2



Putting it all together

Once framework mapped out, encourage deliberation

- **“How are you thinking about this?”**
- **“What are you thinking?”**
- **“What’s the most important thing for you?”**

After patient has time to process, make recommendation

- **“Based on what I’m hearing from you, would it be alright if I make a recommendation?”**

Challenging questions and statements

Hope in uncertainty

“God’s going to bring me a miracle.”

- “I hope that for you too.”
- “I really admire and respect your faith.”
- “Can you share with me what a miracle might look like for you?”

“How much time do I have left?”

- “That’s a great question and I’m going to answer it the best I can. Can you tell me what you are worried about?”
- That’s a great question and I’m going to answer it the best I can. Can you tell me what information would be most helpful to you?”

Abandonment

"Are you saying there is nothing more you can do?"

- "I can't even imagine how (emotion) this must be."
- "It sounds like you might be feeling (emotion)."
- "I wish we had a treatment that could fix this. I am here to help you through this."

"Are you giving up on me?"

- "I wish we had more treatments to offer. Our team is committed to help you in every way we can."
- "We will be here for you."
- "It sounds like you may be feeling (emotion)."
- "We will work hard to get you the support that you need."

Grief and loss

“My mom is a fighter!”

- “She is. She is such a strong person and has been through so much.”
- “I really admire that about her.”
- “I admire how much you care about your mom.”
- “Tell me more about your mom and what matters most to her.”

“Are you telling me my dad is dying?”

- “I wish I had better news.”
- “This must be such a shock for you.”
- “I can’t even imagine how difficult this must be.”

Case study

Mr. Green

Mr. Green is a 69-year-old man who was diagnosed with cT3N2bM0 squamous cell carcinoma of the supraglottic larynx in April 2022 following work up for sore throat and voice hoarseness.

He underwent definitive concurrent chemoradiation with cisplatin 40 mg/m2/week and IMRT 70 Gy/35 fx completed August 2022.

Found to have pulmonary metastatic disease on surveillance imaging in February 2023.

Mr. Green

Received first line palliative therapy carboplatin pembrolizumab and 5FU x 4 cycles. 5FU required dose reduction x 2 due to oral mucositis.

Continued maintenance pembrolizumab through August 2023. Discontinued due to disease progression.

Prolonged hospitalization x 2 in September and October 2023 for pneumonia and AKI.

Due to frailty, started single agent cetuximab q 14 days November 2023 – February 2024, dose reduced for skin toxicities.

He missed several appointments, reporting “I don’t feel up for it today.”

Mr. Green

Most recent imaging shows progressive disease, now with moderate left pleural effusion.

Mr. Green has rescheduled this imaging review appointment multiple times. Tells the staff “I just need time to recover.”

Mr. Green’s niece Sally finally convinces him to come in to talk about his imaging and next steps.

He was late to today’s appointment; Sally reports it was hard to get him out of bed and it took 30 minutes to get him from the house into the car.

When you see Mr. Green, he has lost weight, with notable temporal wasting, he is anxious, tachypneic, and sitting in wheelchair.

He tells you “I want to fight this.”

Using the Serious Illness Conversation Guide, which question would you ask Mr. Green first?

1. “If your cancer is getting worse, what are you hoping for?”
2. “Can I share my understanding of what to expect with your cancer?”
3. “How much information about what lies ahead with your cancer would be helpful to discuss today?”
4. “What gives you strength as you think about the future?”
5. I am not sure

Mr. Green

Mr. Green tells you he wants to know what is going on with his cancer. He tells you to “be straight with me.”

As you discuss his frailty and the concern, he will not tolerate further treatment, Mr. Green becomes frustrated and tells you “I think you are giving up on me.”

Using the Emotions step of the SPIKES protocol, your best response is

1. “Why don’t we talk about this more after you have had time to think things over?”
2. Assure him you are not giving up on him and talk about the next line of chemotherapy.
3. Ask him what his hopes for his health are considering his progressive disease.
4. “This must be overwhelming and scary. Can you tell me what worries you most?”

Key Takeaways

Breaking Bad News is never easy

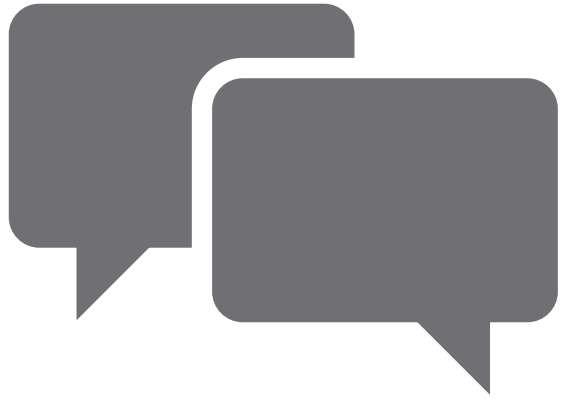
Avoid jargon

Take your time

Allow patients time to process

Provide space for emotions

Collaborate with your interdisciplinary colleagues



References

Ariadne Labs. Serious illness care. Serious illness conversation guide. May 2023. Accessed March 12, 2024. https://www.ariadnelabs.org/serious-illness-care/

Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. *Oncologist*. 2000;5(4):302-311. doi:10.1634/theoncologist.5-4-302

Bousquet G, Orri M, Winterman S, Brugière C, Verneuil L, Revah-Levy A. Breaking Bad News in Oncology: A Metasynthesis. *J Clin Oncol*. 2015;33(22):2437-2443. doi:10.1200/JCO.2014.59.6759

Graham LJ, Hite A, Harris J, Belcher G. Silent Conversations: Goals of Care and End-of-Life Quality in Relapsed High-Risk Leukemia. *J Adv Pract Oncol*. 2023;14(5):380-387. doi:10.6004/jadpro.2023.14.5.3

Kruser JM, Nabozny MJ, Steffens NM, et al. "Best Case/Worst Case": Qualitative Evaluation of a Novel Communication Tool for Difficult in-the-Moment Surgical Decisions. *J Am Geriatr Soc*. 2015;63(9):1805-1811. doi:10.1111/jgs.13615

Lilley EJ. Navigating Difficult Conversations: Breaking Bad News and Exploring Goals of Care in Surgical Patients.*Surg Oncol Clin N Am*. 2021;30(3):535-543. doi:10.1016/j.soc.2021.02.010

Marschollek P, Bąkowska K, Bąkowski W, Marschollek K, Tarkowski R. Oncologists and Breaking Bad News-From the Informed Patients' Point of View. The Evaluation of the SPIKES Protocol Implementation. *J Cancer Educ*. 2019;34(2):375-380. doi:10.1007/s13187-017-1315-3

Miller EM, Porter JE, Barbagallo MS. The experiences of health professionals, patients, and families with truth disclosure when breaking bad news in palliative care: A qualitative meta-synthesis. *Palliat Support Care*. 2022;20(3):433-444. doi:10.1017/S1478951521001243

References

Postavaru GI, McDermott H, Biswas S, Munir F. Receiving and breaking bad news: A qualitative study of family carers managing a cancer diagnosis and interactions with healthcare services. *J Adv Nurs*. 2023;79(6):2211-2223. doi:10.1111/jan.15554

Schwarze ML. "Best Case/Worst Case Training Program." University of Wisconsin Madison Department of Surgery. 2016. Accessed March 12, 2024. https://www.hipxchange.org/BCWC

- Demonstration video available at https://www.youtube.com/watch?v=FnS3K44sbu0

Taylor LJ, Nabozny MJ, Steffens NM, et al. A Framework to Improve Surgeon Communication in High-Stakes Surgical Decisions: Best Case/Worst Case. *JAMA Surg*. 2017;152(6):531-538. doi:10.1001/jamasurg.2016.5674

Weeks JC, Catalano PJ, Cronin A, et al. Patients' expectations about effects of chemotherapy for advanced cancer.*N Engl J Med*. 2012;367(17):1616-1625. doi:10.1056/NEJMoa1204410

White N, Reid F, Harris A, Harries P, Stone P. A Systematic Review of Predictions of Survival in Palliative Care: How Accurate Are Clinicians and Who Are the Experts?. *PLoS One*. 2016;11(8):e0161407. Published 2016 Aug 25. doi:10.1371/journal.pone.0161407

Thank you!