LCC Session 55
CanMEDS Competency: Communicator, Breaking Bad news
Dr. M. Ladhani

What will happen in this session?

You will meet with your group and practice the skills of Breaking Bad News using role plays. You have been given 5 role play scenarios to distribute, but you may also make up your own cases if you wish. Each role play has a patient part and a doctor part. Residents should have an opportunity to play both a patient and a doctor part during the session. Residents should only read the case instructions for the particular part of a case that they are playing, to allow for a more spontaneous and natural interview.

You may want to divide your small group up into even smaller groups of 2 or more residents who complete the role plays simultaneously to maximize practice time. Alternatively, you may wish to remain working together as one group, observing a pair in their role play, and making use of "time outs" and group feedback to enhance learning. Your group will decide which format best suits your level of comfort and learning needs.

Suggested Time 60 minutes.

Readings:


Also attached.

Facilitators Notes:

Please print out the scenarios (attached) and bring to the session. The interview observation guide attached is for reference only and does not need to be filled out on each resident. You may want to use it to provide feedback.
### Preparation:

- set up appointment as soon as possible
- allow enough uninterrupted time; if seen in surgery, ensure no interruptions
- use a comfortable, familiar environment
- invite spouse, relative, friend, as appropriate
- be adequately prepared re clinical situation, records, patient’s background
- doctor to put aside own “baggage” and personal feelings wherever possible

### Beginning the session / setting the scene

- summarise where things have got to date, 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 warning first that difficult information 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; repeat important points

• relate your explanation to the patient’s framework

• do not give too much information too early; don’t pussyfoot but do not overwhelm

• give information in small “chunks”; categorise information giving

• 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

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**Being sensitive to the patient**

• read the non-verbal clues; 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 in their needs

• encourage expression of feelings, give early permission for them to be expressed: 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

• check patient’s previous knowledge about information 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
- Give hope tempered with realism (“preparing for the worst and hoping for the best”)
- Ally yourself with the patient (“we can work on this together ...between us”) i.e. co-partnership with the patient / advocate of the patient
- Emphasise the quality of life
- Safety net

Follow up and closing

- Summarise and check with patient
- 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

Remember doctor’s anxiety - re giving information, previous experience, failure to cure or help

This framework for “breaking bad news” is based on a number of people’s work:


References
various authors make different recommendations about how this task should be accomplished. Buckman suggests a direct preliminary question such as “if this condition turns out to be something serious, are you the type of person who likes to know exactly what is going on?”. Maguire suggests a hierarchy of euphemisms for the bad news, pausing after each to gain the patient’s reaction. Other authors suggest making a more direct start to giving the news after a warning shot and gauging how to proceed as you go: they argue that patients who wish to use denial mechanisms will still be able to blank out what they do not want to hear.
SCENARIO A. (PATIENT) Jamie Maple

You are a 54 year old accountant, married with two teenage children. Previous health has been good until two years ago when a routine colonoscopy (done because of positive family history) revealed a Stage 3 colon cancer. You were told this had a high cure rate with surgery and chemo. You underwent a hemicolectomy and have a colostomy. You underwent 6 months of adjuvant chemotherapy (with the intent of cure). You have six monthly follow up appointments in the cancer clinic, and colonoscopy is done every year, as well as CT scan which you are told should be done annually for 3 years. You’ve had the routine blood work and CT scan two weeks ago, and today are attending the clinic for your regular appointment. These appointments always make you nervous, but you usually feel great afterwards, knowing everything is ok. Lately your life has been very stressful, your job is not secure in the current recession, you have lost a lot of savings in the market crash, you are irritable with your family and not sleeping as well. Your father died of colon cancer at age 61.

You’ve noticed some mild abdominal discomfort lately and your energy isn’t as good, but you are quite sure this is related to your stress level and lack of sleep.
SCENARIO A  Jamie Maple  (DOCTOR)

You are a family doctor in a community of 100,000. Besides your family practice, you work one day a week in the community cancer clinic, where you supervise chemotherapy and deal with symptom management and follow up appointments. You enjoy this work as it provides variety to your professional life.

You have met Jamie Maple two years ago when he underwent 6 months of adjuvant (for cure) chemotherapy for resected carcinoma of the colon. He is here today for routine q6monthly follow up appointment. He has had CT scan (routine) and lab work.

The blood tests show a mild elevation in liver enzymes (new), an elevation of the CEA (carcinoembryonic antigen, a marker for bowel cancer) to 8, previously 2.3, normal is up to 5. CT shows retroperitoneal lymph nodes (new) and 3 new lesions in the liver, interpreted by the radiologist as metastatic. You review the CT yourself, and indeed there is no doubt your patient’s cancer has recurred in the liver and the retroperitoneal nodes. The patient tells the nurse who interviews him that he has not been as energetic lately, and has noticed a bit of abdominal discomfort, which he is sure is related to work stress. He looks nervous.

(What does this mean? He/she now has stage 4 colon cancer. This is incurable. Surgery is not an option. He/she will be offered palliative chemotherapy, with the intent of controlling disease. Depending on response to chemo, he/she may live a couple of years.)
SCENARIO B (PATIENT)   JAN BIRCH

You are a 58 year old physician, very respected as the chief of family practice at a large prestigious medical school. You are married to a psychiatrist, and have 3 young adult children all in university. You lead a busy life, active in the university and community, with published research, and a busy social life. You’ve noticed a mild cough which didn’t go away in three months so you organized your own chest xray. You were dismayed when it showed an infiltrate and CT was recommended. You went to a friend who is a respirologist who organized the CT which showed a lesion. CT guided biopsy showed adenocarcinoma. You are a lifelong non-smoker with no significant exposure to second hand smoke. You have been referred for an oncology opinion, and this is a comprehensive clinic where surgeons and oncologists and radiation oncologists work together. Your respirologist has organized a bone scan and CT head, for staging, and these have been done. You have not yet been given those results. You are hoping that this lung lesion is resectable and therefore curable. Your first interview is with the senior resident in oncology.
You are the senior resident in oncology, working today in a comprehensive lung clinic together with thoracic surgery and radiation oncology. Your attending staff person is away presenting a paper in Rome and you are working the clinic for him. (This is not unusual, you have passed your exams.)

Your patient is Dr. Jan Birch, a family physician on staff at your medical school, very well regarded by colleagues and students. He/she is a non-smoker. Recently developed cough but no other symptoms. Chest xray was abnormal, leading to CT which showed a lesion. CT guided biopsy showed adenocarcinoma cells. The patient knew all this from the referring respirologist. He/she has now had bone scan and CT head and these are showing extensive metastatic disease in the bones, and at least 4 metastatic lesions in the brain.

(What does this mean? He/she has stage 4 lung cancer, which is incurable. Surgery is not an option. Likely you will recommend palliative chemotherapy, although this can be delayed until he/she is more symptomatic. Usual recommendation is for whole brain radiation for the cranial mets. This causes complete and permanent hair loss. This radiation is not curative either, but usually delays the symptoms of cranial mets (seizure, cognitive impairment, stroke-like symptoms). Usual survival in this situation is about a year to 18 months depending on response to treatment. She is at risk for errors in judgment, probably shouldn’t be working as a physician at this time)
Your are the mother/father of 2 teenage children. You are divorced. Your 17 year old daughter has been a bit difficult lately, grades dropping, staying out late, you don’t like the sort of friends she’s hanging out with. Tonight she is out past her curfew, and at 1 am you receive a call from the police telling you your daughter and others have been in a serious car accident, and your daughter is at the emergency department at Grand River Hospital. You frantically drive to the hospital. You give your name to a nurse and are directed to a small waiting area where you are alone. You are told the doctor will speak with you. You wait half an hour for the doctor. You try to telephone your ex-spouse but are unable to get through.
You are on duty in Grand River emerg, doing a 1 pm to 1 am shift. At about midnight 4 ambulances arrive with 4 teenage victims of a car accident on Highway 7 between Kitchener and Guelph. The second-call emerg physician is called in to help. The two teenage boys have minor injuries. One teenage girl has a head injury and multiple fractures. She is resuscitated, intubated, and is awaiting transfer through Criticall to a neurosurgical unit. You will need to accompany her in the ambulance.

The fourth patient, Jennifer, arrives with absent vital signs, intubated and receiving CPR from the paramedics. She has extensive bruising of the chest wall and numerous other injuries. Clinical situation suspicious of serious cardiac trauma. Monitor shows asystole. In spite of aggressive resuscitation you are unable to revive her. You pronounce death at 1:20 am. The charge nurse informs you that one of her parents is waiting in the quiet room to talk to you.
You are a 34 year old female, married for 6 years, had one previous miscarriage and difficulty conceiving after that. Finally after 3 years of trying you are overjoyed to get pregnant again. You are a type 1 diabetic, somewhat noncompliant when you were younger but very careful with diet and insulin since your mid 20s. Your obstetrical care is being shared between your family doctor and obstetrician, and you are seeing an endocrinologist about your diabetes which is well controlled. You are now 34 weeks pregnant, planning the decorating of the baby’s room and winding down your duties at work. You have great trust in your family doctor, who you’ve know since your teens.

You realize that you have not felt the baby move since last evening, and today you call the family doctor’s office. Your doctor is off sick today. His partner is covering. This doctor is much younger, you’ve met him/her once before and liked him/her. He/she arranges for an ultrasound to be done today. The ultrasound lab is in the same building. You go for the ultrasound. As the technician is performing it, she becomes rather quiet and you notice she turns the screen away slightly so you can’t see it. After a few moments she tells you she’s going to speak to the doctor, and excuses herself. You wait about 15 minutes for the doctor. You tried to reach your husband at work but he is out of the office at a meeting
SCENARIO D   SANDY BEECH (DOCTOR)

You are a young family physician, in a two person practice with a somewhat older GP who is well respected and liked by his patients. He calls in sick on this day, leaving you to cover the practice. The staff cancel as many of his patients as they can, but some cannot be cancelled so you are left with a very busy day. It is your 4 year old son’s birthday and you are hoping to get home in good time. Your nurse receives a call in the early afternoon from a 34 year old woman, 34 weeks pregnant. Your partner has extensive obstetrical experience, and is managing this pregnancy together with an obstetrician and endocrinologist, because the patient is diabetic. The patient, Sandy Beech, reports to the nurse that she has not felt fetal movement since last evening. You request an urgent ultrasound, hoping it will be normal and the patient can just be reassured. However, at about 4 pm the ultrasound tech comes to your office and asks to speak to you urgently, reporting to you that there is no fetal heart detected. You go to the ultrasound suite to speak to the patient.

(What does this mean? This is the dreaded scenario of intrauterine death. The patient will have to have labour induced and deliver a stillborn infant. Likely you will arrange for the obstetrician to do this, this evening or tomorrow. )
You are a 58 year old cabinetmaker, planning on taking early retirement this June and doing some traveling with your wife of 35 years. You have two grown children who are married with young families. You've been a smoker, but have always enjoyed good health, requiring no medications. You immigrated to Canada in the 1950s from Latvia. You are proud of the life you established here, and of the new split-level townhouse you just purchased in time for retirement. You are physically active, cycling to work, hiking, tennis, recently took up golf.

Recently, for the last couple of months, you’ve noticed some funny feeling in your hands. You try to ignore it but you find you’re now having difficulty doing up buttons and doing fine work. You’ve dropped tools at work. On Saturday while changing your shirt, you noticed some “tremoring” of the muscles in your left arm. You show your wife, who makes an appointment with your family doctor. You basically never go to the doctor, so you don’t know him/her well, but he/she seems nice and your wife thinks highly of him/her. The doctor examines you, then books an EMG, which is a nerve conduction test, on your arms. This is done three days later, and you are returning today to your family doctor for the results.
SCENARIO E  LYNSAY TAMARACK  (DOCTOR)

Lyndsay Tamarack is a 58 year old cabinetmaker, not known well to you, but you know his wife well as a patient. She makes an appointment for her husband because of funny feelings in his hands and “dropping things” You saw the patient last week. He reported difficulty with his buttons, with doing fine work, and difficulty holding onto tools at work. He also reports his muscles are “tremoring”

On examination you notice fasciculation of the biceps muscles of both arms. You’ve never seen this before but you’re reasonable sure that’s what it is. You call a neurologist who obligingly sees him within a few days and does an emg (electromyelogram, or nerve conduction test) and consultation. The neurologist calls you and tells you the examination and emg results confirm that the patient has amyotrophic lateral sclerosis, or Lou Gehrig’s Disease. This is what you suspected. The neurologist has not told the patient anything. He returns today to see you for the results of his tests.

(What does this mean? Lou Gehrig’s Disease has a dreadful prognosis of progressive neurological decline. First the distal muscles are affected, then the impairment spreads proximally. Patients lose their mobility and their ability to care for themselves, then their swallowing, finally respiratory muscles go. Death from respiratory failure is inevitable, usually in 1-2 years. Rare cases live longer. There is no known treatment that has any effect. There may be research trials. University Hospital in London has an ALS clinic)
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<th>Builds Relationship</th>
<th>Comments</th>
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<td></td>
<td>- Greets and shows interest in patient as a person</td>
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<td>- Uses words that show care and concern throughout the interview</td>
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<td>- Uses tone, pace, eye contact, and posture that show care and concern</td>
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<td><strong>Opens Discussion</strong></td>
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<td>- Allows patient to complete opening statement without interruption</td>
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<td>- Asks &quot;Is there anything else?&quot; to elicit full set of concerns</td>
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<td>- Explains and/or negotiates an agenda for the visit</td>
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<td><strong>Gathers Information</strong></td>
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<td>- Begins with patient’s story using open-ended questions (e.g. “tell me about…”)</td>
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<td>- Clarifies details as necessary with more specific “yes/no” questions</td>
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<td>- Summarizes and gives patient opportunity to correct or add information</td>
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<td>- Transitions effectively to additional questions</td>
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<td><strong>Understands Patient’s Perspective</strong></td>
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<td>- Asks about life events, circumstances, other people that might affect health</td>
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<td>- Elicits patient’s beliefs, concerns and expectations about illness and treatment</td>
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<td>- Responds explicitly to patient’s statements about ideas and feelings</td>
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<td>Shares Information</td>
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<td>• Assesses patient’s understanding of problem and desire for more information</td>
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<td>• Explains using words that patient can understand</td>
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<td>• Asks if patient has any questions</td>
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<th>Reaches Agreement</th>
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<td>• Includes patient in choices and decisions to the extent he/she desires</td>
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<td>• Checks for mutual understanding of diagnostic and/or treatment plans</td>
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<td>• Asks about patient’s ability to follow diagnostic and/or treatment plans</td>
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<td>• Identifies additional resources as appropriate</td>
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<th>Provides Closure</th>
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<td>• Asks if patient has questions, concerns or other issues</td>
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<td>• Summarizes</td>
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<td>• Clarifies follow-up or contact information</td>
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<td>• Acknowledges patient and closes interview</td>
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**ADDITIONAL COMMENTS:**

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STUDENT SIGNATURE  FACILITATOR(S) SIGNATURE