

# **EPEC for Veterans**

Education in **P**alliative and **E**nd-of-life Care for Veterans

## **Trainer's Guide**

### **Module 3**

## **Communicating Difficult News**

**Emanuel LL, Hauser JM, Bailey FA, Ferris FD, von Gunten CF, Von Roenn J, eds. EPEC for Veterans: Education in Palliative and End-of-life Care for Veterans. Chicago, IL, and Washington, DC, 2012.**

EPEC® was created with the support of the American Medical Association and the Robert Wood Johnson Foundation. Subsequent funding has been provided by the National Cancer Institute and the Lance Armstrong Foundation. The EPEC for Veterans Curriculum is produced by EPEC and the EPEC for Veterans Work Group through funding provided by the US Department of Veteran Affairs. Acknowledgment and appreciation are also extended to Northwestern University's Feinberg School of Medicine, which houses EPEC.

Special thanks to the EPEC for Veterans team and all other contributors and reviewers.

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## Module 3 trainer's notes

### Principal message

The ability to communicate effectively is essential to the provision of good palliative care.

### Module overview

Communicating information, whether it is good or bad news, is an essential skill for clinicians of all disciplines. This module presents a 6-step approach to structuring communication. The steps include getting started, finding out what the Veteran knows, finding out how much the Veteran wants to know, sharing information, responding to feelings, and planning/follow-up. Approaches for handling the family who says 'don't tell' the Veteran and for using an interpreter when language is a barrier are discussed.

### Preparing for a presentation

#### 1. Assess the needs of your audience

Choose from the material provided in the module according to the needs of your expected participants. It is better for participants to come away with a few new pieces of information, well learned, than to come away with a deluge of information, but remembering nothing.

#### 2. Presentation timing

Allow sufficient time for participants to introduce themselves.

The suggested timing for each part of this module is:

Introduction	2-3 minutes
Trigger tape & discussion	5-7 minutes
Lecture presentation	20 minutes
Role-play	20 minutes
<u>Summary</u>	<u>2-3 minutes</u>
Total	49-53 minutes

### **3. Number of slides: 20**

### **4. Preparing your presentation**

The text in the syllabus was not designed to be used as a prepared speech. Instead, the slides have been designed to guide your presentation. Although the slides closely follow the text of the syllabus, they do not contain all of the content. Their use presumes that you understand the content. You may want to make notes on the slide summary pages to help you prepare your talk in more detail and provide you with notes to follow during your presentation.

Practice your presentation using the slides you have chosen, and speaking to yourself in the kind of language you expect to use, until it is smooth and interesting and takes the right amount of time.

### **5. Preparing a handout for participants**

The syllabus text and slides in the **Trainer's Guide** were designed to be reproduced and provided to participants as a handout, either in its entirety, or module by module. If the entire curriculum is not being offered, please include the following in each handout:

- **EPEC for Veterans Front Cover Page**
- **EPEC for Veterans Acknowledgment Pages** (to acknowledge the source of the material)
- Syllabus and slides for **Module 3**

### **6. Equipment needs**

- computer with DVD capability or separate DVD player
- flipchart and markers for recording discussion points

## **Making the presentation**

### **1. Introduce yourself**

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your clinical experience related to the information you will be presenting.

### **2. Introduce the topic**

Show the title slide for the module. To establish the context for the session, make a few broad statements about the importance of communication as a clinical skill. For instance, note that many patients and families remember more about how communication was presented than anything else about their care. Tell participants the format and time you

will take to present the session. Identify any teaching styles other than lecture that you intend to use.

### **3. Review the session objectives**

Show the slide with the session objectives listed. Read each objective and indicate those that you are planning to emphasize.

### **4. Show the trigger tape or present the clinical case**

After reviewing the objectives for the session, show the trigger tape or present the clinical case below. It has been designed to engage the audience in discussion and provide an appropriate clinical context for the session.

#### **Clinical case**

H.G. is a 67-year-old Mexican-American Vietnam Veteran who is a retired mechanic. Dr. O'Brien has cared for his family for three years. One week ago H.G. presented to Dr. O'Brien with a chief complaint of weakness. On physical exam, he had occult blood in his stool. Laboratory testing revealed iron-deficiency anemia. H.G. underwent colonoscopy, which demonstrated a mass in the descending colon. The biopsy confirmed the diagnosis of adenocarcinoma. The trigger tape shows a scene in which Dr. O'Brien gives him the news of his colon cancer.

#### **Discussion**

If the discussion is slow to start, you may want to ask more direct questions, like:

- Have they had similar patients?
- How did the patient react to the clinician's questions?
- How did the clinician start? What was well done? What was missing?
- What did the clinician do to foster a comfortable atmosphere?
- How did the physician address the patient's concerns?

Use the discussion to set the stage for the material to follow. Don't let the discussion focus on a critique of the technical quality of the trigger tape or how 'real' the players seemed. If the participants don't like something that was said or done in the trigger tape, ask them how they would handle this situation.

#### **Setting limits to discussion time**

Limit discussion of each scene of the trigger tape to no more than 5 minutes, then move on to the presentation. To help move on if the discussion is very engaged, try saying something like:

- Let's hear two last points before we move on.
- Now that you have raised many of the tough questions, let's see how many practical answers we can find.

## **5. Present the material**

### **Recommended style: Interactive lecture combined with role-play**

A brief interactive lecture will permit you to engage your audience, yet cover your chosen material within 15-20 minutes.

#### **Role-play**

Introduce the role-play exercise. Develop your own scenario for the small groups to use, or use the one from the trigger tape.

Ask participants to divide into clinician, patient, and observer or family member groups. One way to do this is to ask them to 'count off' from 1 to 3. Then, tell the '1s' they are clinicians, '2s' they are patients, and '3s' they are observers or family members. Ask the clinicians to deliver the news for 10 minutes, then stop for small group discussion for 10 minutes.

After the small group discussion, lead the larger group in a discussion of the results. Ask for feedback first from the clinicians, then from the patients, then from the observers. Use the flipchart or overhead projector to capture the important discussion points. Use the discussion to interweave the key take-home points from the syllabus.

#### **Standardized or real patient**

One possibility in this didactic, interactive approach is to demonstrate the communication by interviewing a real, or a standardized, patient in front of the group after presenting the approach in the lecture-based format. After the staged interview, ask the group for their comments. Use the discussion to emphasize the points made during the lecture.

## **6. Key take-home points**

1. The vast majority of people want to know if they have a life-threatening illness.
2. Use the 6-step approach, particularly when learning this skill.
3. When language is a barrier, verify that translators will be comfortable and sufficiently skilled in translating the news you are about to give.
4. Avoid using family members as primary translators. It confuses their role, frequently compromises the therapeutic quality of the interview, and may compromise some Veterans' desires for confidentiality.

## **7. Summarize the discussion**

Briefly review each part of the presentation. Recap 2 or 3 of the most important points that were discussed.

## **8. Post-test/evaluation**

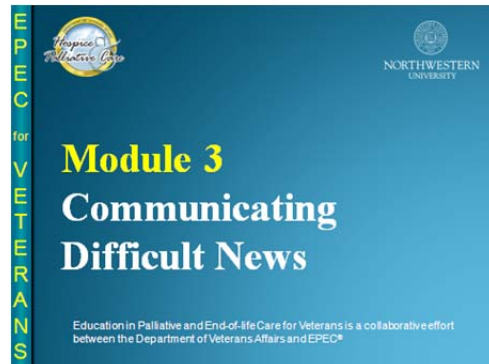
Ask the participants to evaluate the session.





## Abstract

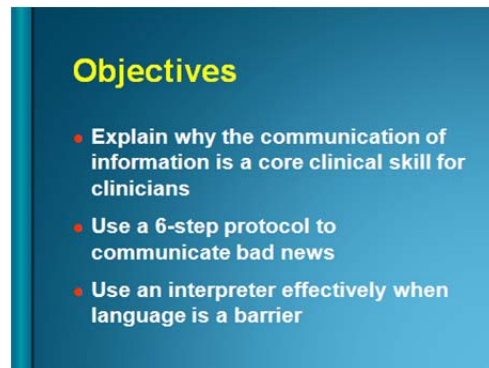
Slide 1



Communicating information, whether it is good or bad news, is an essential skill for clinicians. This module presents a 6-step approach to structuring communication. The steps include getting started, finding out what the Veteran knows, finding out how much the Veteran wants to know, sharing information, responding to feelings, and planning/follow-up. Approaches for handling the family who says ‘don’t tell’ the patient, for discussing prognosis, and for using an interpreter when language is a barrier are also discussed.

## Objectives

Slide 2



After studying this module, clinicians will be able to:

- explain why the communication of information is a core clinical skill for clinicians;
- use a 6-step protocol to communicate bad news; and
- use an interpreter effectively when language is a barrier.

## Clinical case

Slide 3



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H.G. is a 67-year-old Mexican-American Vietnam Veteran who is a retired mechanic. Dr. O'Brien has cared for him and his family for three years. One week ago, H.G. presented to Dr. O'Brien with a chief complaint of weakness. On physical exam, he had occult blood in his stool. Laboratory testing revealed iron-deficiency anemia. H.G. underwent colonoscopy, which revealed a mass in the descending colon. The biopsy confirmed the diagnosis of adenocarcinoma. This is a visit in which Dr. O'Brien discusses this new diagnosis with him and his family.

## Introduction

Slide 4



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Communicating information, whether it is good or bad news, is an essential skill for clinicians. Many find it challenging to communicate effectively, especially when this involves a diagnosis of a potentially life-threatening or life-limiting illness. Some clinicians feel inadequately prepared or inexperienced in giving bad news. Others fear the news will be so distressing and will adversely affect the patient, family or therapeutic relationship.

The vast majority of Americans want to know if they have a life-threatening illness.<sup>1</sup> Studies in other cultures reveal surprisingly similar data.<sup>2,3</sup> Although cultural variations are important, communicating in a direct and compassionate manner typically improves peoples' ability to plan and cope, encourages realistic goals and autonomy, supports

patients emotionally, strengthens the clinician-patient relationship, and fosters collaboration among the patients, families and clinicians.<sup>4</sup>

## 6-steps for communicating effectively

Slide 5

6-step protocol ...

1. Set the stage
2. What does the Veteran know?
3. How much does the Veteran want to know?

Adapted from Robert Buckman

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Slide 6

... 6-step protocol

4. Share the information
5. Respond to patient, family feelings
6. Plan next steps and follow-up

Adapted from Robert Buckman

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Although this module is designed as a guide to the communication of ‘bad’ news, the protocol it presents may be viewed more generally as a **model for communicating any type of important information** to Veterans and their families.

## Types of bad news

Although the stereotypical example of “bad” news is a new diagnosis of cancer or other advanced illness, there are many types of difficult news that clinicians are called on to discuss. In the setting of palliative care, the most common type of difficult news is likely about advancing of disease and lack of curative options. Other types of difficult news include withdrawing and withholding of various forms of life support, many different test results, a decision that a Veteran can no longer go home and must remain in a facility and the decision to enter hospice. Each of these situations can benefit from a structured approach to communication.

This recommended 6-step protocol has been adapted from *How to Break Bad News: A Guide for Health Care Professionals* by Robert Buckman.<sup>5,6</sup> He and colleagues have subsequently developed a mnemonic, SPIKES, to help clinicians remember the 6 steps.<sup>7</sup> Others have reported similar approaches.<sup>8,9</sup>

# SPIKES

SPIKES is an acronym for the following steps:

**S**etting. Getting started.

**P**erception. What does the patient know?

**I**nvitation. How much does the patient want to know?

**K**nowledge. Sharing the information.

**E**motion. Responding to feelings.

**S**ubsequent. Planning and follow-up.

This 6 step-protocol is most effective when used as a framework to guide important aspects of an interaction in which difficult information is shared rather than a script to be followed rigidly. For example, although the height of the emotional reaction may be after hearing the news, a compassionate clinician will be noting and responding to feelings and emotions throughout the interaction.

## Step 1: Setting

Slide 7

**Step 1: Setting**

- Plan what you will say  
confirm medical facts  
don't delegate
- Create a conducive environment
- Allot adequate time  
prevent interruptions
- Determine who else the patient  
would like present

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Before meeting with the Veteran, review what will be discussed. Confirm the medical facts of the case. Ensure that all the needed information is available, rehearse what you will say.

If several team members will be present, it is important for the team to meet in advance to coordinate roles. Sometimes an appointment to share bad news involves a single physician; other times it involves multiple physicians, nurses and other health care professionals. In either case, consider the different roles of different clinicians in this interaction and discuss in advance.<sup>10</sup> This need not be a separate meeting, but rather can occur just before the visit to discuss the bad news. Questions to be considered when the team meets to discuss in advance include: Who will lead the interaction? What topics will be covered? What will the roles of the different clinicians be during the interaction? The

goal is not to script the meeting but rather coordinate roles and have a clear agenda for the visit.

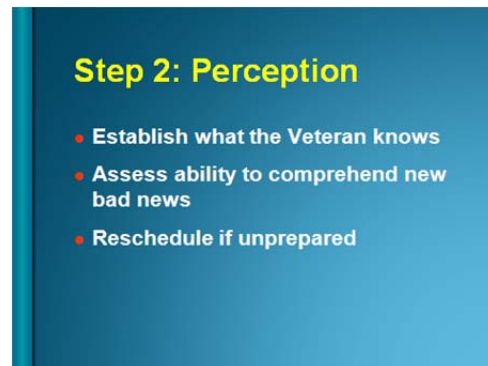
Create an environment conducive to effective communication. Ensure privacy and adequate seating to the extent possible. Ensure that a box of tissues is handy and a glass of water.

Allot adequate time for the discussion. Try not to slip this into a short interval between other critical tasks or attempt the meeting when you yourself are feeling distracted or preoccupied by other tasks. Try to prevent interruptions – for example, arrange to hold telephone calls and pages or give your pager to someone else.

In some cases, a Veteran will have an appointment at which the main task will be to discuss bad news – such as a family meeting for a hospitalized patient or a previously scheduled appointment for an outpatient to discuss the results of a CT scan. In the case of a scheduled appointment, determine in advance who else the Veteran would like to have present for the discussion. Possibilities include family, significant others, surrogate decision makers. Also consider which other members of the interdisciplinary team, e.g., nurse, social worker, chaplain, psychologist, etc. should be present.

## Step 2: Perception

Slide 8



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Despite lengthy charts and many years of contact with the medical system, there may be discordance between what the Veteran knows about his or her condition and what the clinicians think he or she knows.<sup>11</sup> Therefore, it is important to start the discussion by establishing what the Veteran and family know about the Veteran's illness.

Questions might include:

- “What do you understand about your illness?”
- “How would you describe your medical situation?”
- “Have you been worried about your illness or symptoms?”
- “What have other doctors tell you about your condition or any procedures that you have had?”
- “When you first had symptom X, what did you think it might be?”

- “What did Doctor X tell you about why he sent you here?”
- “Did you think something serious was going on when...?”

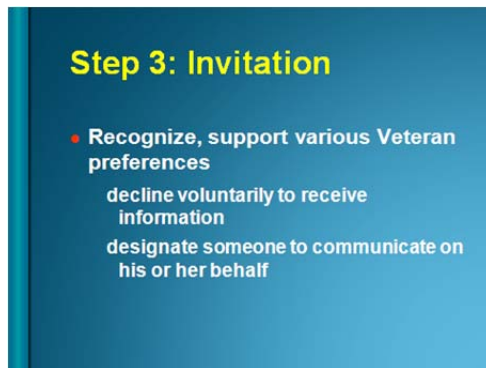
Each of these questions is an open-ended way of letting the Veteran and his or her family describe their understanding and allows the clinician to get a baseline of their knowledge of their condition.

Occasionally, a Veteran may have difficulty participating in the conversation. He or she may fall silent and seem unprepared or unable to respond. In this case, try to ask more specific and concrete questions in order to clarify what the Veteran understands about his or her medical history and recent investigations. This can be done by asking more concrete questions such as “What did doctor X tell you about the test you got?” or “Did you have a sense of what the test was for?”

For those Veterans where family is distant, they can be included through conference calling. Some Veterans may be isolated from family and special efforts should be made to see if friends can participate in discussions. Sometimes Veterans view VA as their family. There may be special issues of psychiatric illness or other conditions that need special attention. If you suspect that this might be the case, it is more important than usual to consult in advance with other clinicians caring for that Veteran.

### Step 3: Invitation

Slide 9




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After establishing how much the Veteran *does* know, the next task is to establish how much the Veteran *wants* to know.

People's preferences for information as well as their ability to understand and manage that information differ depending on sociodemographic factors, psychological factors, information processing and coping styles, personality, culture, religion, and education. Each Veteran has the right to voluntarily decline to receive any information and may designate someone else to communicate on his or her behalf. Therefore, it is important to ask the Veteran and family how they would like to receive information and how much information they would like to receive. If the Veteran prefers not to receive critical information, establish to whom the information should be given. Sometimes, this will

have been done earlier in the course of caring for the Veteran, but sometimes this step happens for the first time in the sharing of difficult information.

Possible questions include:

- “If this condition turns out to be something serious, do you want to know?”
- “Would you like to know all the facts?”
- “Would you like me to tell you the full details of your condition? If not, is there somebody else you would like me to talk to?”
- “Some people really do not want to be told all of the specifics of what is happening medically, but would rather their families be told instead. What do you prefer?”
- “Do you want me to go over the test results now, and explain exactly what may be wrong?”
- “Who would you like me to talk to about these issues?”

By asking these questions, a clinician models open communication and allows the Veteran to consider how to include his or her family in communication. The way the Veteran answers the questions will give clues about her/his educational level, cultural beliefs and family dynamics. Listen carefully and observe everyone’s responses to your questions. Use this experience to influence how you deliver your news.

## Step 4: Share the information

Slide 10

**Step 4: Share the information ...**

- Say it, then stop
  - avoid monologue
  - avoid jargon and euphemisms
  - pause frequently
  - check for understanding
  - use silence, body language

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All of the discussion to this point has been about preparation to share difficult news and to provide opportunities to determine what the Veteran already knows and how he or she would like to have information presented. These steps are crucial preparation for the specific step of sharing the news.

Deliver the information in a sensitive but straightforward manner. Start by letting the Veteran know that you have bad news, then share the facts. This is sometimes called a ‘warning shot.’ This cautioning that the news might not always be good can help prepare



the Veteran and family for ‘bad’ news. An example of a “warning shot” might be: “I have some difficult news” to share.

After this, communicate the information and then stop. Avoid delivering all of the information in a single, steady monologue. Use simple language that is easy to understand, while avoiding technical jargon or euphemisms. Pause frequently. Use silence and body language as tools to facilitate the discussion.<sup>12</sup>

Do not minimize the severity of the situation. Well-intentioned efforts to ‘soften the blow’ may lead to vagueness and confusion.

You might choose to break the ‘bad’ news by using language like:

- “I feel badly in having to tell you this, but the growth turned out to be cancer”
- “I’m afraid the news is not good. The biopsy showed that you have colon cancer”
- “I’m afraid I have bad news. The bone marrow biopsy shows that you have leukemia.”
- “Your current condition and our tests are all suggesting that your heart failure has become much worse.”

## Step 5: Respond to feelings

Slide 11

**Step 5: Respond to feelings ...**

- **Affective response**  
Tears, anger, sadness, love, anxiety, relief, other strong emotions
- **Cognitive response**  
Denial, blame, guilt, disbelief, fear, loss, shame, intellectualization
- **Basic psychophysiologic response**  
Fight-flight

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Slide 12

**... Step 5: Respond to feelings**

- **Be prepared for**  
outburst of strong emotion  
broad range of reactions
- **Give time to react**
- **Listen quietly, attentively**
- **Encourage descriptions of feelings**
- **Use non-verbal communication**

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Veterans and their families may respond to bad news in a variety of ways. Some respond emotionally with tears, anger, sadness, anxiety, relief, or other strong emotions. Others experience denial, blame, guilt, disbelief, fear, or a sense of loss or shame, or may even



intellectualize why the situation is happening. A few may demonstrate reflexive psychophysiologic responses such as ‘fight or flight’ and may even want to leave the room or totally withdraw into themselves.

Outbursts of strong emotion make some clinicians uncomfortable.<sup>13</sup> Be aware of your own reactions and tendencies such as to want to flee, fix the problem or fill the space. Give the Veteran and family time to react. This can be very challenging for clinicians of all backgrounds. Be prepared to support them through a broad range of reactions. Supporting Veterans and their family members requires tolerating and managing your own emotions so you can be fully present for them.

Listen quietly and attentively. Acknowledge their emotions. Ask them to describe their feelings:

- “I imagine this is difficult news.”
- “You appear to be angry. What you are thinking right now?”
- “Does this news frighten you?”
- “Tell me more about how you are feeling about what I just said.”
- “What worries you most?”
- “What does this news mean to you?”
- “I wish the news were different.”

It can be helpful to validate and normalize the Veteran’s and family’s responses. Allow time for the Veteran and family to express all of their immediate feelings. Don’t rush them. The most frequent error that clinicians make is to talk.<sup>14</sup> Try to resist this. A second mistake is to try to immediately reassure. Phrases such as “don’t worry” or “It’ll be all right” run the risk of being overly optimistic and minimizing the Veteran’s emotional reaction. What is most valuable at times like these is presence, as opposed to specific words. A shared understanding of the news and its meaning can facilitate future decision-making and planning.

## Step 6: Plan next steps and follow-up

Slide 13

Slide 13 is a presentation slide with a blue background. The title 'Step 6: Plan next steps and follow-up ...' is written in yellow. Below the title, there are two bullet points in white text: 'Plan for the next steps' followed by 'additional information, tests' and 'treat symptoms, referrals as needed' on separate lines, and 'Discuss potential sources of support'.

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### ... Step 6: Plan next steps and follow-up

- Give contact information, set next appointment
- Before leaving, assess:
  - safety of the Veteran
  - supports at home
- Repeat news at future visits

After the news is delivered, establish a plan for the next steps. This may include gathering additional information or performing further tests. Explain plans for additional treatment and discuss symptom management. Offer to help the Veteran tell other members of his/her family about the illness, available treatment options and the possible impact. Arrange for appropriate referrals. Discuss potential sources of emotional and practical support, e.g., family, significant others, friends, social worker, spiritual counselor, peer support group, professional therapist, hospice, home health agency, etc.

Reassure the Veteran and family that they are not being abandoned and that you and others on the palliative care team will be actively engaged in an ongoing plan. Indicate how the Veteran and family can reach you and other clinicians involved in care to answer additional questions. For both inpatients and outpatients, establish a time for a follow-up appointment or visit. For outpatients, this will mean a next appointment, for inpatients, it may mean rounds later in the day or the next morning. In either situation, it is important to specify that at these future visits, additional concerns can be addressed.

If this is an interaction in the outpatient clinic, ensure that the Veteran will be safe when he or she leaves. Is he or she able to drive home alone? Is the Veteran distraught, feeling desperate, or suicidal? Is there someone at home to provide support?

At future visits, elements of this six-step protocol may need to be revisited. Many Veterans and families require repetition of the news to gain a complete understanding of their situation.

## Specific communication challenges

### When family says 'don't tell'

Slide 15

**When family says 'don't tell' ...**

- Legal obligation to obtain informed consent from the Veteran
- Promote congenial family alliance

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Slide 16

**... When family says 'don't tell'**

- Ask the family:
  - Why not tell?
  - What are you afraid I will say?
  - What are your previous experiences?
  - Is there a personal, cultural, or religious context?
- Talk to the Veteran together

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At times, family members may ask a clinician not to tell the Veteran the diagnosis or other important information. While it is the clinician's legal and ethical obligation to obtain informed consent from the Veteran, an effective therapeutic relationship requires a congenial alliance with the family. People also have the right to delegate family members to receive information on their behalf.

Rather than confronting a family's request with, 'I have to tell the patient,' inquire why they are concerned. Possible questions include:

- "Can you share with me why you don't want me to tell?"
- "Is there something that you are afraid I will say?"
- "Tell me about your past experience with cancer (a diagnosis)?"
- "Are there personal, religious or cultural beliefs that are important to know?"

Suggest that you go to the Veteran together to ask how much s/he wants to know about her/his health and what questions there might be. Discuss the potential burdens of secrecy and the opportunities that come with open communication.

These situations may require significant negotiation. In particularly difficult cases, support from other colleagues or the institutional ethics committee may be helpful. Ultimately, it may be decided, after discussion with the Veteran, that details of diagnosis

and prognosis and treatment decisions will be discussed only with the family. However, unless the Veteran has previously indicated that he or she wants no information, withholding the diagnosis or important information about prognosis or treatment from the Veteran is neither ethically nor legally acceptable. A helpful way to address this when you are with the Veteran alone is to say: "Some people sometimes want their family to receive information first. Is that something that you would want?"

Clinicians do not need to feel constrained to practice in a way that compromises care or feels unethical. For example, if a physician and the family cannot come to agreement about the best way to communicate, the physician may choose to withdraw from the case and transfer care to another physician.

There are ethnic and cultural differences in the preferred handling of information.<sup>15</sup> Some of these involve different emphases on personal autonomy vs. family decision making. However, while knowledge of such differences may be a useful background to conversations where bad news is shared, global conclusions about them rarely help with decision making for an individual. Ask Veterans about general preferences for handling of medical information and decision making early in the clinical relationship before significant information needs to be shared. Although this is not always possible when you are meeting a Veteran for the first time in a hospitalized setting, it can occur in the course of a longitudinal relationship between a clinician and a Veteran.

## **‘I’m sorry’**

The phrase “I’m sorry” can be a powerful empathic response in situations of difficult news. In rare cases, it may be interpreted by the family to imply that the clinician is responsible for the situation. This should not be a reason to avoid it. If you use the phrase, make sure to use it to show empathy. For example, saying, “I’m sorry to have to tell you this,” or, “I wish things were different” are effective at communicating empathy without conveying responsibility for the condition.<sup>16</sup> These phrases can help you as a clinician connect emotionally with the Veteran.

## **Team communication**

Veterans in palliative care settings are frequently cared for by an interdisciplinary team. This is one of the strengths of palliative care but it can also be a challenge in terms of coordinating and realizing what each team member is doing.<sup>17</sup> The best teams benefit from flexibility, but also from clear expectations at the outset, clear roles for different team members and an open and transparent communication style. Although it is beyond the scope of this module to discuss all the aspects of team communication, there are two key points for palliative care teams and the discussion of bad news.


1. Try to meet as a team before the appointment or visit to deliver bad news. The goal of this is to discuss the specific topic of the visit as well as each team members’ role in the conversation. It is most important to specify with the team who will be leading the interaction. This can be any team member- it should

generally be the person who has the closest relationship with the Veteran which may be the physician, nurse, nurse practitioner or social worker.

2. Debrief after the visit to discuss specific next steps. This debriefing can also have a self-care function in allowing team members to discuss their experience of the interaction.

## Communicating prognosis

Slide 17



**Communicating prognosis**

- Many reasons behind Veterans asking about prognosis
- Before answering questions, inquire the reason for asking
- Consider responding by giving a range of time
- Emphasize the limits of prediction

Veterans often ask about prognosis. There may be many motivations for this request. Some want to have a sense of their future, so they can plan their lives. Others are terrified and hope that you will reassure them that things are not so serious. Even when Veterans do not ask explicitly, it may be helpful for clinicians to proactively introduce by asking something like: “There are some patients who want to know more about their prognosis (or life expectancy); there are others who don’t. Would you like to know more about our opinions on this?” One of the advantages of asking this type of ‘permission’ is that it may give insight into the Veterans’ religious or spiritual beliefs, his or her coping style and his or her family. Examples of answers that can lead to these insights include:

- “I don’t want to know because it is not up to me or you; it’s up to God”
- “I’ve never been someone to plan, so I don’t want to know.”
- “My family never likes to hear that kind of information, but I do.”

Each of these answers invites further explanation by the clinician and can be an opportunity to discuss coping, religious beliefs and family support.

In either case, whether they have asked spontaneously or you have introduced the subject, before directly answering their questions about prognosis, inquire about their reasons for asking.

Questions might include:

- “What are you expecting to happen?”
- “How specific do you want me to be?”
- “What experiences have you had with others with a similar illness?”

- “What experiences have you had with others who have died?”
- “What do you hope/dream will happen?” and
- “What are some of your fears about the future?”

Consider the implications of the prognostic information you provide. Veterans who wish to plan their lives may want information that is more detailed. Those who are very scared may do better with answers that are more general. Definitive answers, e.g., “You have 6 months to live,” should be avoided: they are more often wrong than right and run the risk of producing disappointment if the time proves to be less, and anger or frustration if you have underestimated the patient’s lifespan. At the other extreme, answers such as “I don’t know” or “It is up to higher powers than me” tend to be unhelpful because they actually minimize how much a clinician does know about a particular illness.<sup>18,19</sup> They may also be perceived as abandonment.

Instead, consider responding by giving a range of time that encompasses an average life expectancy and reflects both medical knowledge and uncertainty, such as “hours to days,” “days to weeks,” “weeks to months,” “months to years,” etc.

Alternatively, indicate averages such as “one third of people will do well a year from now, half will live about 6 months, exactly what will happen for you, I don’t know.”

After giving a range, it may help to emphasize the limits of prediction by saying something like “I can’t tell what this will mean for you. We need to hope for the best, while we plan for the worst. We can’t predict surprises and should plan in case something happens. We’ll have a better sense over time about how things will evolve for you.”

Always caution Veterans and their families that unexpected events can happen. Suggest that they get their affairs in order so they won’t be so vulnerable if something unexpected does occur. Reassure them that you will be available to them to deal with issues and support them throughout illness, whatever happens. Help clarify what can be realistically expected and distinguish this from what might be wished for, or what is most feared.

Finally, make sure to debrief with the Veteran. Even when desired, prognostic information may be very hard to hear. A question such as, “I/We have shared a lot of difficult information. How are you doing with hearing all of that?” can be very helpful.

## When language is a barrier

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### When language is a barrier...

- Use a skilled interpreter
  - Familiar with medical terminology
  - Comfortable translating bad news
- Consider telephone translation services

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### ... When language is a barrier

- Avoid family as primary interpreters
  - Confuses family members
  - How to translate medical concepts
  - Modify news to protect Veteran
  - Supplement the translation
- Speak directly to the Veteran

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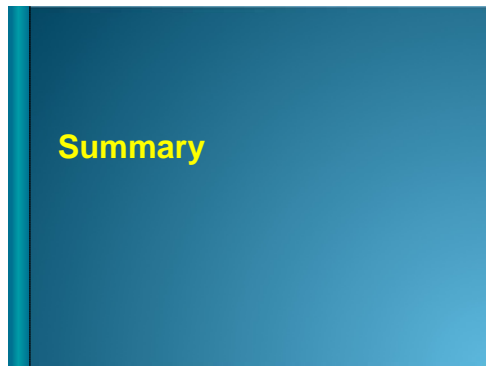
This same 6-step protocol for communicating information effectively can be used when the Veteran and clinician do not speak the same language. The assistance of an experienced interpreter who understands medical terminology and is comfortable translating bad news is required. There are several services in North America that offer translation by telephone if there is no one directly available. If possible, brief the interpreter before the encounter and reassure them that their role is only to translate. Verify that they will be comfortable translating the news you're about to give. Most Veterans will have functional English skills since this is a requirement of military service, however, in times of stress and illness use of interpreters for their native language and for family who do not speak English as first language communication with the assistance of a translator will be important.

If possible, avoid using family members as primary interpreters. It confuses their roles in the family and may raise issues of confidentiality. Additionally, family members may not know how to translate the medical concepts the clinician is trying to convey, and/or they may modify the news to protect the Veteran. Instead, when family members are present who do speak both languages, ask them to supplement the primary translation and support the Veteran and other members of the family. There may, however, be cases when an interpreter is not available and a clinician will need to rely on a family member to translate. In these cases, ask the family member to try to translate the words as concretely as possible.

When working with an interpreter, sit in a triangular arrangement so that you can face and speak directly to the Veteran, yet still turn to look at the interpreter. Speak in short segments and then give the interpreter time to convey the information. Verify that the Veteran and family understand and check for an emotional response, considering the cultural and personal context. An example of a brief guideline for the use of medical interpreters has been developed by the American Association of Medical Colleges (AAMC) and is available at [http://www.aamc.org/students/medstudents/interpreter\\_guide.pdf](http://www.aamc.org/students/medstudents/interpreter_guide.pdf).

## Summary

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This 6-step protocol for delivering information offers guidelines and practical suggestions on how to communicate any medical information effectively and compassionately, and respond to a Veteran's and family's feelings and needs. Approaches for handling the family who says "don't tell" the patient, the use of a translator, and the communication of prognosis also are discussed. Tips are provided for when language is a barrier. The protocol is a framework for approaching this essential task for physicians and all other members of the interdisciplinary team. It is not meant to be a rigid set of rules that must be followed in all cases. Once you have learned the basic steps, learn to tailor it to your day-to-day practice patterns.

## Key take-home points

1. The vast majority of people want to know about it if they have a life-threatening illness.
2. Use the 6-step approach, particularly when learning this skill.
3. When language is a barrier, verify that interpreters will be comfortable and sufficiently skilled in translating the news you are about to give.
4. Avoid using family members as primary interpreters. It confuses their role, frequently compromises the therapeutic quality of the interview, and may compromise some Veterans' desires for confidentiality.



## References

- <sup>1</sup> Field MJ, Cassel CK, eds. *Approaching Death: Improving Care at the End of Life*. Washington, DC: National Academy Press; 1997; 59-64.
- <sup>2</sup> Sekimoto M, Asai A, Ohnishi M, et al. Patients' preferences for involvement in treatment decision making in Japan. *BMC Fam Pract*. 2004; 5: 1.
- <sup>3</sup> Jadalla A, Sharaya H. A Jordanian view about cancer knowledge and attitudes. *Cancer Nurs*. 1998; 21(4): 269-273.
- <sup>4</sup> Back A, Arnold R, Tulsky J. *Mastering Communication with Seriously Ill Patients: Balancing Honesty with Empathy and Hope*. New York, NY: Cambridge University Press; 2009.
- <sup>5</sup> Buckman R. *How to Break Bad News: A Guide for Health Care Professionals*. Baltimore, MD: The Johns Hopkins University Press; 1992; 65-97.
- <sup>6</sup> Garg A, Buckman R, Kason Y. Teaching medical students how to break bad news. *CMAJ*. 1997; 156(8): 1159-1164.
- <sup>7</sup> 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): 302-311.
- <sup>8</sup> Faulkner A, Maguire P. *Talking to Cancer Patients and Their Relatives*. New York, NY: Oxford University Press; 1995: 58-70.
- <sup>9</sup> Quill TE, Townsend P. Bad news: delivery, dialogue, and dilemmas. *Arch Intern Med*. 1991; 151(3): 463-468.
- <sup>10</sup> Carson-Stevens A, King EJ. The paraprofessional's role in breaking bad news. *J Palliat Med*. 2008; 11(2): 144-145.
- <sup>11</sup> Skinner KM, Miller DR, Lincoln E, Lee A, Kazis L. Concordance between respondent self-reports and medical records for chronic conditions: experience from the Veterans Health Study. *J Ambul Care Manage*. 2005; 28(2): 102-110.
- <sup>12</sup> Hagerty RG, Butow PN, Ellis PM, Dimitry S, Tattersall MH. Communicating with realism and hope: incurable cancer patients' views on the disclosure of prognosis. *J Clin Oncol*. 2005; 23(6): 1278-1288.
- <sup>13</sup> Clever SL, Tulsky JA. Dreaded conversations: moving beyond discomfort in patient-physician communication. *J Gen Intern Med*. 2002; 17(11): 884-885.
- <sup>14</sup> Roter DL, Larson S, Fischer GS, Arnold RM, Tulsky JA. Experts practice what they preach: a descriptive study of best and normative practices in end-of-life decisions. *Arch Intern Med*. 2000; 160(22): 3477-3485.

- <sup>15</sup> Kagawa-Singer M, Blackhall LJ. Negotiating cross-cultural issues at the end of life: “You got to go where he lives.” *JAMA*. 2001; 286(23): 2993-3001.
- <sup>16</sup> Quill TE, Arnold RM, Platt F. “I wish things were different”: Expressing wishes in response to loss, futility, and unrealistic hopes. *Ann Intern Med*. 2001; 135(7): 551-555.
- <sup>17</sup> Goldsmith J, Wittenberg-Lyles E, Rodriguez D, Sanchez-Reilly S. Interdisciplinary geriatric and palliative care team narratives: collaboration practices and barriers. *Qual Health Res*. 2010; 20(1): 93-104.
- <sup>18</sup> Sinclair CT. Communicating a prognosis in advanced cancer. *J Support Oncol*. 2006; 4(4): 201–204.
- <sup>19</sup> Hagerty RG, Butow PN, Ellis PM, Dimitry S, Tattersal MH. Communicating prognosis in cancer care: a systematic review of the literature. *Ann Oncol*. 2005; 16(7): 1005-1053.