Finding Grace in Disgrace

Sushil G Kachewar, MD, DNB
Rural Medical College
Loni, India

Devidas S Kulkarni, MD, DMRD
Rural Medical College
Loni, India

Smita B Sankaye, MD
Rural Medical College
Loni, India

Address for correspondence:
Sushil G Kachewar, MD, DNB
Rural Medical College
Loni, India
Email: sushilkachewar@hotmail.com

Received, 24April, 2012
Accepted, 10 May, 2012

All things are good and glorious when a doctor delivers good news. It could be the delivery of a healthy child or even disclosing the fact that the suspected dreaded tumor is completely curable. But things are not easy when delivering bad news about an inoperable deformity or an incurable ailment.

Delivering the news of an incurable ailment like cancer to the patients, their relatives as well as the referring colleague is an episode of emotional turmoil not only for the receiver but also for the giver of this news. It is many times perceived as disgrace. Nothing can make bad news good. But a proper method of conveying it to patients or their relatives can ease the emotional shock and make it more acceptable.

This article focuses on the yet unfocussed role of the modern day doctor who needs to be armed with advanced skills for an effective doctor-patient relationship and reviews various strategies that can help them to deliver good as well as the bad news with courage and confidence. Thus grace can be found by the doctor as well as the patient in so called disgrace or the incurable malady.

Key Words: pad news, cancer, doctor-patient relationship, imaging, malignancy, medical education, technology, surgery

The field of doctor-patient relationship has grown by leaps and bounds- thanks to the advances in science and technology, law and commerce. Earlier there was not much doctor-patient interaction as well as doctor-patient relationship as the patients used to accept unquestionably, whatever was pronounced by the doctor as the dime reality of the day.

Then came the era of breakthroughs in science and technology, progress in patient-consumer laws and advances in commerce making treatments affordable to many. The inclusion of doctor community into the Consumers Protection Act (CPA) in many nations gave impetus to the evidence based practice where the physician or the surgeon adopted the policy of getting a radiological as well as laboratory diagnosis before declaring the diagnosis as well as treating any patient. So to the chagrin of many and the joy of few, doctor-patient interaction and therefore relationship also grew by leaps and bounds. Today any doctor cannot just avoid them as the financial stakes involved in this interaction are high. Moreover it is the right of the patient (consumer) to know the result of the test (the commodity) for which he has paid and about the outcome of surgery/treatment for which he is willing to pay.

To a doctor who is not trained in delivering bad news, it might seem very distressing and inhumane to disclose a deadly diagnosis to the patient or their relatives[6]. This stressful situation of the health service provider was as grim in the yester years when modern methods of managing incurable maladies were not available as it is today; though modern advances have made it possible to treat many 'deadly' diseases of the past. The most important reason that contributes to this moral turpitude is a complete lack of scientific approach towards delivering bad news that is seen globally.

The aftermath that follows following delivery of bad news often leaves the doctor as well as the patient in a lot of stress. Following examples would better highlight this fact. Diagnosing a genetic disorder like Down`s syndrome, Achondroplasia, Heart defects etcetera during routine

prenatal ultrasound and then attempting to declare or explain these results to the expectant parents takes a heavy toll on the doctors. Similarly diagnosing an inoperable tumor or metastatic spread on CT scan or MRI can and conveying the news to the patient or relatives can be equally distraughtful. With the advances in metabolic imaging, MRS can diagnose inborn errors of metabolism[6] like Leigh`s disease and Pyruvate dehydrogenase deficiency even in children. Explaining this to the parents is also daunting and calls for high communication skills. The scenarios exemplified in this paragraph fall under the broad umbrella of "Bad News" which is defined as "Any information that adversely and seriously affects an individual's view of his or her future is considered a bad news[3]."

To any healthcare worker who is not trained in delivering bad news, the experience of disclosing the deadly diagnosis to the patient or their relatives is a heavy ordeal[4]. But breaking bad news is an important communication skill which we all must master irrespective of whether we are the surgeons, the physicians, the oncologists or even just interns or medical students. A nonscientific approach in breaking bad news; can not only create misunderstanding on the part of patient about the seriousness of the illness and chances of survival;[10] but may also be a cause of litigation in the future.

To prevent this we must be aware of the components of this mighty task. The verbal component consists of delivering bad news, coupled with multiple other skills; like managing patient's emotions, involving the patient and family members in decision-making, clarifying expectations about care and cure, and keeping hopes alive[2]. The medico legal implications must also be kept in mind as in many countries the patients have to be provided with as much information as they desire about their illness and about all available treatment options [5, 8].

How human beings will respond to bad news is unpredictable. Some instantaneously become fearful, some go into denial mood, some enter the 'why me' stage while very few seek more information to start a complete recovery; or if not possible a quality-of-life decision plan. Hence the act of delivery of the bad news and the response to it can be quite stressful and emotionally draining for the health service provider as well.

Important Strategies for Breaking Bad News are

1] The traditional method in which the bad news is directly delivered to the patient or relatives after the examination; only if it is asked for by them. Many times this blunt on the face approach may take them by surprise and result in emotional outbursts.

2] There is a new six step protocol for breaking bad news called as SPIKES[2] which emphasizes that any complex task can be achieved only by a stepwise approach. The six steps involved in it are:

S - Setting up an interview: This needs mental rehearsal, arranging an uninterrupted session in adequate privacy with a relaxed patient and his dear ones if so desired or requested.

P - Patients Perception: Open-ended questions are used to understand how the patient perceives the medical situation; before discussing medical findings with them.

I- Invitation by patient: Wait till the patient is ready and invites you to disclose the results.

K- Knowledge: Warning the patient that bad news is coming, give facts in bits that are apt as per their understanding so that they accept the news in right spirit.

E- Emotions: Address patient's emotional reactions with emphatic response and support them.

S- Strategy: Discuss the future plan, when the patients are ready and offer all options only if asked. It is always better that the doctor who has referred the patient does this job.

The protocol not only increases the confidence of medical students as well as practitioners in formulating a plan for breaking bad news; but also ensures that the bearer of bad news is less affected psycho physiologically during the process of disclosure by following this protocol.

3] A Saudi Arabian[1] study on preferences of mothers' about breaking bad news pertaining to newborns, suggests that a "one-size-fits-all" approach is inappropriate. The approach has to be tailor made. Hence they advocate the use of a reversible, written informed consent kept in mother's medical records; that can be utilized to guide the process of breaking bad news, if needed, as the best solution to this diversity in preferences.

4] BREAKS[7] is a modern protocol for breaking bad news. It involves following six steps: B -Background, R-Rapport building, E – Exploration of patients understanding, A –Announcement of the diagnosis, K-Kindling hope and S –Summarizing the scenario. This is a recently introduced protocol that calls for discussion, further elaboration and expression so that breaking bad news truly becomes a part of the art of medicine.

To summarize, communicating with distressed patients is difficult and demands deliberate measures to handle the grim situation. Doctors as well as the patients; suffer significant stress when subjected to this ordeal[9]. When the doctor delivering the news becomes emotional he might instill in himself a feeling of guilt and a sense of failure for not fulfilling the patient's expectations. Moreover, the modern advances in the field of medicine and surgery has also led to unrealistic expectations in patients from their doctors. In such an environment; poor communication skills on the part of doctor, can lead to misunderstandings and ultimately result in doctors burnout, stress and even litigations. That is why many avoid discussing distressing information about the poor prognosis. But as communication is a skill; it can be learned and mastered with practice and experience. Therefore we as the news givers; must choose our protocol to deliver good as well as bad news. Reforms in medical education technology should also foster this art and science of delivering bad news so as to enable medical students, interns as well as the practitioners in finding grace in disgrace.

References

1. Al-Abdi SY, Al-Ali EA, Daheer MH, Al-Saleh YM, Al-Qurashi KH and Al-Aamri MA. Saudi mothers' preferences about breaking bad news concerning newborns: a structured verbal questionnaire. **BMC Medical Ethics12**: 15, 2011
2. Baile WF, Buckman R, Lenzi R, Glober G,Beale EA and Kudelka AP. SPIKES-A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer. **The Oncologist 5:** 302-311, 2000.
3. Buckman R. Breaking Bad News: A Guide for Health Care Professionals. Baltimore: Johns Hopkins University Press:15,1992
4. Friedman HS. Physician management of dying patients: an exploration. **Psychiatry Med 1:**2 95-305, 1970
5. Goldberg RJ. Disclosure of information to adult cancer patients: issues and update. **Journal of Clinical Oncology 2:** 948-955, 1984
6. Kachewar SG, Sankaye SB, Kulkarni DS. Radio-imaging for detecting congenitally defective metabolic pathways: A review. **Australasian Medical Journal 4, 9:** 480-484, 2011
7. Narayanan V, Bista B, Koshy C. 'BREAKS' protocol for breaking bad news. **Indian J Palliative Care 16:** 61-65, 2010
8. Ptacek JT, Eberhardt TL. Breaking bad news. A review of the literature. **JAMA 276:** 496-502, 1996
9. Scalliet P, Etienne AM: Teaching communication and Stress management skills to junior physicians dealing with cancer patients: A Belgian Interuniversity Curriculum. **Supportive Care Cancer 14:** 454-461, 2006
10. Siminoff LA, Fetting JH, Abeloff MD. Doctor-patient communication about breast cancer adjuvant therapy. **Journal of Clinical Oncology 7:**1192-1200, 1989