HOW TO BREAK BAD NEWS

Common Problem Seminar
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1. Interviews about bad news consist of
- a component of divulging information
- a dialogue between the profession and the patient that may provide a therapeutic benefit for the patient

2. Bad news itself causes distress: a supportive and sensitive interview may minimize the eventual amount of distress.

3. Being aware of cultural/moral expectation of patient is invaluable in appropriate communication.

The Six-Step Protocol

STEP 1 GET THE SETTING RIGHT

- Get the physical context comfortable
- Where?
- Who should be there?
- Starting off - introductions, expectations, agenda

STEP 2 FIND OUT HOW MUCH THEY ALREADY KNOW

- Open ended questions - What did previous doctors tell you? What did the tests show? What does it all mean?

STEP 3 FIND OUT WHAT THEY WANT TO KNOW

- There are people who need lots of information - others want none. What kind of person are you? Do you want your family involved in the sharing of information?

STEP 4 SHARE THE INFORMATION

- Decide on your agenda (diagnosis/treatment plan/prognosis/support)
- Start from the patient's starting point (Aligning)
- Educating and informing to the extent desired
  Use English or French not Medspeak
  Check reception frequently
  Reinforce and clarify the information frequently
  Check your communication level (adult-adult, etc)
  Listen for the patient's agenda
  Try to blend your agenda with the patient's

STEP 5 RESPOND TO THE PATIENT'S FEELINGS

- Identify and acknowledge the patient's reaction
  eg. "Normal" emotional responses to receiving "bad news" - A classification of reactions seen in practice

TYPE A

- Minimal Reaction
- Calm, controlled, joking
- Asking pertinent questions
- Emotional Denial

TYPE B

- Quite upset
- Breaking into tears
- Expression of fears, concerns
- Grieving the loss of good and healthy aspects of life

TYPE C

- Angry reaction
- Guilt about "why me?"
- Feeling responsible for causation
- Blaming someone or something
- Emotionally labile

TYPE D

- Disbelieving reaction
- Argumentative or withdrawn
- Denying diagnosis, test, procedure
- Dazed state of emotional shock yet relief that diagnosis is made at last

Each patient may have one or several coping responses. Acknowledging and supporting these responses are critical

STEP 6 GIVE A CLEAR FOLLOW UP PLAN

- Organizing appropriate referrals
- Hopeful but honest message
- Reframing the goals of care
- Making a contract and follow-through with return appointment
- Avoid entering a 'conspiracy of silence' or alliance with family members that require limiting your communication with the patient

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נושא: The difficult patient - AAFP

Management of the Difficult Patient

AAFP - American Family Physician

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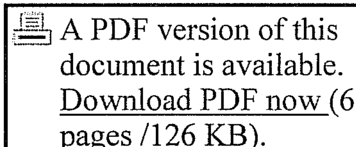
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All physicians must care for some patients who are perceived as difficult because of behavioral or emotional aspects that affect their care. Difficulties may be traced to patient, physician, or health care system factors. Patient factors include psychiatric disorders, personality disorders, and subclinical behavior traits. Physician factors include overwork, poor communication skills, low level of experience, and discomfort with uncertainty. Health care system factors include productivity pressures, changes in health care financing, fragmentation of visits, and the availability of outside information sources that challenge the physician's authority. Patients should be assessed carefully for untreated psychopathology. Physicians should seek professional care or support from peers. Specific communication techniques and greater patient involvement in the process of care may enhance the relationship. (Am Fam Physician 2005;72:2063-8. Copyright © 2005 American Academy of Family Physicians.)

A 45-year-old woman is being treated for depression, chronic daily headaches, type 2 diabetes, hypertension, and hyperlipidemia. She is taking eight prescription medications. Multiple antidepressants have been tried without improvement in her depressive symptoms. Her blood sugar level remains out of target range. She does not exercise and admits to overeating when feeling depressed. She discloses difficulties with her employer and says her headaches are worsening because of stress. Her weight is slowly increasing. At her next physician's appointment, she demands oral weight loss medications, complaining that nothing else is working. When her physician declines to prescribe them, she shouts, "You don't care about me, or even understand my suffering, because you have obviously never had a weight problem yourself."

SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	Evidence rating	References
Targeted psychopharmacology should be considered for difficult patients who are dysphoric, anxious, or aggressive.	C	31
Physicians with problems managing difficult patients should	C	9, 16, 33-35