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TWELVE TIPS

Twelve tips to manage a breaking bad news process: Using S-P-w-ICE-S – A revised version of the SPIKES protocol

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ABSTRACT

Breaking bad news (BBN) is a difficult task that requires multiple professional competencies. The way it is managed has implications for all involved in the encounter: the patient, family members, and the news provider. Existing guidelines were developed mainly at the turn of the millennium and require updating based on identification of daily clinical needs and pedagogical challenges while teaching the current protocols. Furthermore, there is a need to provide an overview of BBN encounters as a process, rather than a subdivided event, to help practitioners adopt an approach that might serve them in their daily routines. This twelve tips article summarizes research and practical experience for handling BBN encounters, from their preparation, through delivering the news while attending patients and family members' needs, toward documenting the news, and critically reflecting on the interaction. The tips are structured and explained to serve both practitioners and medical educators.

KEYWORDS

Communication skills, breaking bad news, reflective practice; difficult conversations; challenging encounters

Introduction

A bad news encounter is meaningful and challenging for all participants, with implications for patients, family members, and the breaker of the news (hereafter 'the practitioner') (Dosanjh et al. 2001; Ptacek et al. 2001). The way the encounter is managed impacts patients' relationships with their healthcare providers, their treatment choices, adherence to treatment, and the healing process (Girgis and Sanson-Fisher 1998; Munjal 2017). Although many physicians deliver bad news on a near-daily basis (Baile et al. 2000), they often feel intimidated or uncertain about their role in this process and need further guidance (Dosanjh et al. 2001; Clandinin et al. 2011). Medical educators invested efforts to better understand the challenges and to help improve the complex competencies required of health professionals while performing this task (Girgis and Sanson-Fisher 1998; Baile et al. 2000; Ptacek et al. 2001; Rosenbaum et al. 2004; Meitar et al. 2009; Munjal 2017; Karnieli-Miller et al. 2018).

Various protocols have been suggested to improve breaking bad news (BBN) communications (e.g. ABCDE, BREAKS, CONSOLE) (VandeKieft 2001; Narayanan et al. 2010; Kok-Yew Tan et al. 2019). We, like many others, have taught the very helpful stepwise SPIKES protocol that includes six steps: Setting, Perception, Invitation, Knowledge, Emotions & Empathy, and Summary (Baile et al. 2000). Clinically and pedagogically, we repeatedly faced challenges with the clarity and order of specific protocol components (e.g. Invitation), as well as with the flow of managing the encounter. This led us to a deliberative process, resulting in the revised S-P-w-ICE-S protocol. This generic model fits most BBN situations in various clinical specialties and can be easily modified to less 'ideal' situations that require BBN by telephone or video, such as during the current COVID-19 pandemic.

Twelve tips

Tip 1

Prepare yourself

BBN encounters require attentiveness to both informative details and self and others' emotions. Physicians experience various and sometimes conflicting thoughts and emotions: a need to protect the patient, to become a 'rescuer,' helplessness, frustration, anger, identification, sense of failure, self-defense, grief, and fear of illness in themselves and/or loved ones. Earlier studies showed that physicians' personal characteristics, past experiences, values, culture, attitudes, biases, and emotions impact their communication patterns (Suchman et al. 1997; Meitar et al. 2009; Karnieli-Miller et al. 2018). All these might impair their ability to be truly present and attuned to patients' needs. Hence the importance of self-preparation (Novack et al. 1999; Ptacek et al. 1999; De Valck et al. 2001; Libert et al. 2006; Dobie 2007; Meitar et al. 2009).

Preparation requires mindfulness and reflective ability (Karnieli-Miller 2020). We recommend the Preparatory-SPICES model (Meitar et al. 2009) that includes reflection on one's own needs for the setting, perceptions, informational gaps, emotional challenges, and a choice of strategy to deal with perceived challenges. This will help to tailor and manage the encounter and communicate more effectively (Karnieli-Miller et al. 2018; Karnieli-Miller 2020). Based on self-prepration, one might decide to adjust the timing of the conversation, who is present (another colleague, nurse, social worker), wording of information, etc.

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Furthermore, advance preparation of key points and goals for the specific BBN conversation (Stein et al. 2011) allows mental rehearsal and readiness (Baile et al. 2000).

Tip 2

Prepare the patient

BBN is often not a single encounter, but a process that begins when symptoms/pathological lab/imaging results require further investigation. The time before final diagnosis may provide an opportunity to learn more about the patient's preferences and communication style, to understand the most suitable way eventually to break the news. This might include asking direct questions about patients' expectations during medical conversations] 'When discussing your test results, how detailed should I be?' 'Do you prefer to be alone or have a significant other (spouse, interpreter) with you?' [(Baile et al. 2000). Assessing patients' preferences is important because significant others' presence, if preferred, can provide support and buffer stress (Bernson et al. 2011). Establishing this early on in the diagnosis process, while building the practitioner–patient relationship, gives patients time to prepare and assess their own needs and helps practitioners decide how to navigate an approaching BBN encounter. Preparation does not replace ongoing assessment of new preferences expressed verbally and/or non-verbally during the encounter as needs change. When BBN circumstances do not allow a process, the S-P-w-ICE-S protocol TIPS 3–10 can help tailor the encounter.

Tip 3

Setting-S

Creating the best possible conditions for the recipient of the news to feel cared for and respected is critical (Baile et al. 2000). This includes providing a quiet setting, allocating enough time without interruptions, sitting down at eye level with tissues at hand, etc. (Novack et al. 1999; Ptacek et al. 1999; De Valck et al. 2001; Libert et al. 2006; Dobie 2007). BBN encounters in a hectic ER environment, via phone or telemedicine conversations pose multiple challenges and require creativity but mostly awareness and attention to detail. For example, when sharing the news by phone one should check patients' whereabouts and situation. People are sometimes engaged in activities inappropriate for receiving BBN e.g. while driving or caring for a baby or frail person.

Important to the setting is deciding who participates. One should not assume that the presence of loved ones, even if escorting the patient, is the patient's preferred option (Baile et al. 2000; Schofield et al. 2001). Many people prefer to receive bad news when alone with the physician because of potential expression of strong emotions (e.g. bursting into tears) or the need to discuss sensitive issues. Hence the issue of the presence of others should be checked, without creating a sense of emergency ('Did anyone come with you to the clinic today?') If the answer is yes, 'Today, we will talk about your results/diagnosis/treatment option. Would you prefer to have them present while we discuss this?' Adjustments are necessary in situations where the news recipient is not the patient, such as parents of a sick child or an incompetent patient's family. In these cases, one must identify a legal guardian and be sensitive to other family issues possibly affecting the decision of who receives the medical information.

Tip 4

Perception to identify gaps -P

Creating the sense of a safe environment by building trust at the beginning of the encounter is essential and can be achieved through expressing genuine interest in the other (Krupat et al. 2006; Silverman et al. 2013). Before sharing the news, while gathering routine information, it is important to learn and understand the BN receiver/s' perceptions regarding the medical condition and its possible present and future implications. This process is designed to identify gaps, prior to sharing, between how the patient/family perceives the medical situation vs. the actual condition and its implications. Through identifying perceptions and gaps, the practitioner can adjust the quantity and quality of information conveyed, tone, chosen words, pace, and gestures (TIPS 4–10). Direct, open-ended questions invite the patient to share thoughts and feelings (e.g. 'How have you been getting on/feeling since we last met?' 'Would you like to share your thoughts about what might have caused the symptoms/the recent deterioration?' 'What have you been told about the reasoning/results of the test?'). Inviting patients and family to share their views gives them room to voice more complex and unpleasant feelings, psychosocial issues, and lay diagnoses and to expose perception differences among family members (Robinson and Heritage 2006).

The larger the gap identified, the slower the steps to be taken when providing information. A very large gap may call for repeating important pieces of medical history, test results, or issues previously discussed, to help the receivers make sense of the course of events and prepare better.

Tip 5

Warning call & Pause-W

This is a transition stage, from listening and gathering information to sharing the news. In this stage, the news is not actually shared yet. The words serving as a warning call should be chosen carefully, to prepare the recipients, mentally, emotionally, and physically, that bad news is coming, capturing their attention without overwhelming them (Baile et al. 2000; Silverman et al. 2013). The warning call is a point of no return. After a pause, the news will be carefully shared and information provided (see next stages).

The W includes a short sentence carrying a clear message that the forthcoming information is not good. The phrasing used depends on what the receivers of the news have said in the Perception stage, using their wording, if possible. If the patient raised a suspicion that something might be wrong, the phrasing should include a reference to the fact that this is indeed (unfortunately) something the patient has considered. This might increase a patient's feelings of control in this independence-threatening encounter. If the patient's explanation of symptoms was wrong, repeating his/her answer shows respect and signals that the practitioner listened carefully and cares about the disappointment. The W is then

used as an opportunity to reframe: 'I understand you thought hemorrhoids caused the rectal bleeding/that the symptoms were stress related. Unfortunately, the lab results suggest a different diagnosis/unfortunately this is not the case … '). The tone of voice used should be factual, neither overdramatic nor depressive.

A short PAUSE must follow the warning call, allowing the receivers time to brace themselves for what is coming next. The practitioner should watch the patient's body language as s/he anticipates receiving the news.

Tip 6

Ongoing juggling between providing Information, Clarifying, and dealing with Emotions – ICE

Up until this point, the model has a linear, step-by-step frame. The next three stages require sensitive juggling. The steps occur concurrently, integrating providing Information, dealing with Emotions, and Clarifying informational needs and cognitive and emotional availability. This includes frequent shifts in the ICE component order, according to the patient's reaction and needs (e.g. IECICIEC …).

Tip 7

Providing Information-I

The aim of this stage is to provide information about the situation/disease/test results and their factual meaning (Baile et al. 2000). Using simple, clear words, avoiding jargon in a step-wise approach that will help the patient absorb the information better. This includes flexible pace, space for silence breaks to ensure understanding and allow questions and expression of emotions.

Information shared should include the name of the disease or condition and its connection to the symptoms or to the meaning of the lab/imaging results. This should be paced by asking what the patient knows and understands about the condition, answering his/her questions about unclear terms, location, and possible causes and correcting misunderstandings. Explanatory words, drawings, sketches, pictures, or images should be adjusted to patients' needs, with an option to record the conversation for the patients' future reference. The practitioner should be aware that, at this point, s/he may feel that s/he has shed a load–but that the load was actually just transferred to the receiver.

Providing information at this point focuses first on the diagnosis, elaborating further only after clarifying the patient's other information needs (e.g. expected disease course, ontology, prognosis). Treatment options should be addressed later (Tip 10) or in a subsequent encounter.

One should keep in mind that everyone has limited ability to absorb new information at any given time, but more so when emotionally overwhelmed. Managing a BBN encounter is not a lecture about a medical condition and the practitioner is responsible for controlling and pacing the number of details conveyed.

Tip 8

Clarifying informational needs and comprehension-C

Effective explanation and information provision that leads to patients' comprehension and recall includes an iterative clarification process with regular checking that patients understand, to allow cognitive digestion (Silverman et al. 2013). This stage of the protocol helps the practitioner to adjust the amount and content of information given to the needs of all those present.

Throughout the ICE, using various clarification questions, the practitioner learns what the receivers know, what they want to know, what they do not want to know, and what they understand. This includes inquiring about prior knowledge: 'Have you heard about dementia before? What do you know about it?'), assessing the need for more information ('Would you like me to elaborate more on this subject?'), and understanding ('How do you see the situation up till now?') (Stein et al. 2011). This stage should include many invitations to ask questions ('What else would you like me to talk about?' 'Do you have unanswered questions?').

It is important to acknowledge the different informational needs of the various participants (Karnieli-Miller et al. 2012). This may lead to the decision to disclose only part of the information and rearrange the meeting so as to address some of the issues once some participants have left the room or until others have joined, or even to postpone the meeting to a different time.

In the original SPIKES protocol, Clarification was referred to as Invitation, i.e. assessing the patient's wishes and informational needs (Baile et al. 2000). It was located earlier in the protocol, before sharing the news. Many physicians found this confusing since it is impossible to address information needs before giving any indication of the topic of discussion. In its original order, the SPIKES (Baile et al. 2000) has practically turned this invitation into a warning call, leading to a non-contributory reaction such as 'I don't know, tell me everything, I guess.' In this revised protocol, Clarification is suggested instead of Invitation and is located mostly within the ICE.

Tip 9

Exploring emotions and providing empathy-E

Receiving bad news leads to an emotional jolt. Emotions and their expression differ among people and may take various forms throughout the encounter. Emotional distress experienced negatively influences the ability to comprehend the information provided (Dunn et al. 1993; Zwingmann et al. 2017). Emotions should be identified, explored, and actively addressed during the entire encounter, as part of building relationships of trust, openness, and respect (Baile et al. 2000).

The first step in addressing emotions is the awareness that a BBN encounter will always evoke strong emotions, even if they are not explicitly expressed. Another important point is that emotional expression is very much culture-dependent and we have limited ability to interpret emotional expressions of people from cultures very different from our own. Once a clear emotion is identified (verbally and/or non-verbally), the practitioner can name it, non-judgmentally, signaling to the patient that s/he is seen ('I can see you are shocked/angry/overwhelmed/sad … ') followed by an empathic silence, allowing the patient to choose his/her own words or gestures (crying/moaning/turning to look at a family member, etc.), while naming or echoing an emotion, one can make a physical gesture, if

appropriate (leaning forward, touching the patient's shoulder). Exploration of emotion includes attentive silence followed by an open invitation to share ('Would you like to share with me what you are feeling?'). Mostly, this is a time for **being** with, enabling, containing. This is a time for appreciating the uniqueness of the individual's pain. No two people undergo exactly the same sense of shock or anguish since no two people share exactly the same life history, experiences, beliefs, and perceptions. Different people in the room might experience different emotions, which should all be acknowledged, named, and respectfully referred to separately. If the feelings expressed are very different from each other (frustration, sadness) or if feelings are expressed toward one of the other participants (anger, blame), this should not be overlooked. A generalizing remark might help to break the tension in the room, e.g. 'This is a very difficult moment for everybody, often arousing different emotions in different people: expressing the emotions is important' Identifying and acknowledging emotions does not mean that the practitioner accepts or agrees with them but sees what the patient is feeling at the present moment: 'I see that you're very upset as you didn't expect such news showing understanding of their experience.'

In telemedicine conversations, there may be a need for a much longer silence and deeper exploration since the ability to observe nonverbal expression is often limited (seeing face only or seeing one person at a time). The practitioner could remark on the inadequate conditions for BBN, apologize for being unable to be physically present with the patient, and invite the patient to share his/her feelings. In these conversations, it is important to emphasize verbal expression of empathy and to voice understanding and legitimization of the patient's feelings.

Tip 10

Share possible strategy, summarize and support

The last stage of the encounter focuses on planning for the near future. Prior to this, one should clarify whether the patient is ready to proceed to discussing treatment options or defer the discussion to a different session while another family member is present or after overcoming strong emotions. The practitioner should explicitly ask: 'Would you like us to talk about treatment options now, or postpone to a later session?' The only reason to impose treatment option discussion at this point would be a medical emergency requiring on-the-spot decisions or if the encounter concerns the death of a loved one and hence no further meetings will occur. This next step requires full attentiveness and decision-making ability and the practitioner must assess whether the patient's current emotional state will allow effective discussion. It is sometimes appropriate to suggest a break while seeing other patients or to defer treatment decisions to another scheduled date.

At this stage, the patient should have a clear general picture of the form his/her life will take in the near future (hospitalization, recovery from surgery, limited ability for certain daily activities, etc.), and a clear understanding of the current, realistic, possibly achievable goal/s we are striving for. The physician should now clearly discuss possible treatment options, including benefits and side effects, recommend relevant reading material, suggest another meeting for further questions and the option of a second opinion. One should keep in mind that treatment options, in themselves, may be bad news, and may raise informational needs and concerns to be addressed.

An important issue for the practitioner to raise toward the end of the encounter is the possible need to break the news to others, as, for many patients, this is a source of great distress. The practitioner can help with thinking this through or can refer to another staff member to guide the patient in how to break news to children or older family members.

The summary is an additional opportunity to invite patients to ask questions. The session should end by inviting the patient to summarize what s/he has understood from the meeting and to ask any questions (e.g. 'We have discussed so many things today. Would you like to tell me how you see the situation right now?'). The practitioner should then mention the communication channels available to the patient between meetings. If the same practitioner will not be the one to follow up with the patient, s/he must clearly indicate this and name the relevant person or department, if known. A personal note is appropriate here, expressing hope that the patient will achieve the goals discussed above (Stein et al. 2011) and that the medical team will be there to assist.

Tip 11

Document the conversation and update

Many BBN conversations take unexpected turns. Issues planned for discussion are not always actually discussed. This requires documentation including important topics to raise next time. Documentation is helpful also for other healthcare professionals involved in the patient's care. This can prevent another health professional mentioning topics as yet unknown to the patient, avoiding an additional unintended BBN encounter.

Tip 12

Reflection, processing and setting a plan for the next encounter

BBN is inevitably challenging. It takes an emotional toll on all involved, including the breaker of the news, who must allow him/herself time and space to reflect critically on the encounter (Schon 1985; Gibbs 1988; Grant et al. 2017; Karnieli-Miller et al. 2018; Karnieli-Miller 2020). This process is necessary for continuous professional growth and for maintaining his/her own well-being.

Conclusion, closing remarks

BBN encounters are difficult for practitioners, patients, and family members. Viewing BBN as a process in which to address the various needs of all concerned can facilitate effective yet compassionate management of these challenges. This revised SPICES mnemonic (replacing SPIKES-see Table 1) addresses many of the challenges that physicians face on a daily basis. It follows the commonly used routine of medical encounters (building a rapport, taking anamnesis, providing information, making treatment

Table 1. Visual image of the revised protocol.

SPIKES	SP(w)ICES
	
"A sharp-pointed piece of metal set" (Dictionary.com retrieved 2.19.17) hurtful experience	Representing that different people may need different amounts of each ingredient

decisions, summarizing) while emphasizing the special needs of a BBN encounter–both in the Warning call stage and in the subsequent stages of providing Information and dealing with Emotions. It offers practical tools that can be adopted as a daily routine, easily adjustable to a wide variety of situations, and can help turn the spiky challenge of BBN into a spicy serving that is easier to swallow.

Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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