patient's sense of being emotionally and existentially settled and of finding purpose or meaning. Helpful assessment questions can include the following: *How much are you able to find meaning since your illness began? What things are most important to you at this stage?* In addition, it can be helpful to ask how the patient perceives his or her care: *How much do you feel your doctors and nurses respect you? How clear is the information from us about what to expect regarding your illness? How much do you feel that the medical care you are getting fits with your goals?* If concern is detected in any of these areas, deeper evaluative questions are warranted.

Communication Especially when an illness is life-threatening, there are many emotionally charged and potentially conflict-creating moments, collectively called "bad news" situations, in which empathic and effective communication skills are essential. Those moments include communicating with the patient and/or family about a terminal diagnosis, the patient's prognosis, any treatment failures, deemphasizing efforts to cure and prolong life while focusing more on symptom management and palliation, advance care planning, and the patient's death. Although these conversations can be difficult and lead to tension, research indicates that end-of-life discussions can lead to earlier hospice referrals rather than overly aggressive treatment, benefiting quality of life for patients and improving the bereavement process for families.

Just as surgeons plan and prepare for major operations and investigators rehearse a presentation of research results, physicians and health care providers caring for patients with significant or advanced illness can develop a practiced approach to sharing important information and planning interventions. In addition, families identify as important both how well the physician was prepared to deliver bad news and the setting in which it was delivered. For instance, 27% of families making critical decisions for patients in an intensive care unit (ICU) desired better and more private physical space to communicate with physicians, and 48% found having clergy present reassuring.

An organized and effective seven-step procedure for communicating bad news goes by the acronym P-SPIKES: (1) ***p***repare for the discussion, (2) ***s***et up a suitable environment, (3) begin the discussion by finding out what the ***p***atient and/or family understand, (4) determine how they will comprehend new ***i***nformation best and how much they want to know, (5) provide needed new ***k***nowledge accordingly, (6) allow for ***e***motional responses, and (7) ***s***hare plans for the next steps in care. Table 10-2 provides a summary of these steps along with

TABLE 10-2 ELEMENTS OF COMMUNICATING BAD NEWS—THE P-SPIKES APPROACH

Acronym	Steps	Aim of the Interaction	Preparations, Questions, or Phrases
P	Preparation	Mentally prepare for the interaction with the patient and/or family.	Review what information needs to be communicated. Plan how you will provide emotional support. Rehearse key steps and phrases in the interaction.
S	Setting of the interaction	Ensure the appropriate setting for a serious and potentially emotionally charged discussion.	Ensure that patient, family, and appropriate social supports are present. Devote sufficient time. Ensure privacy and prevent interruptions by people or beeper. Bring a box of tissues.
P	Patient's perception and preparation	Begin the discussion by establishing the baseline and whether the patient and family can grasp the information. Ease tension by having the patient and family contribute.	Start with open-ended questions to encourage participation. Possible phrases to use: *What do you understand about your illness?* *When you first had symptom X, what did you think it might be?* *What did Dr. X tell you when he or she sent you here?* *What do you think is going to happen?*
I	Invitation and information needs	Discover what information needs the patient and/or family have and what limits they want regarding the bad information.	Possible phrases to use: *If this condition turns out to be something serious, do you want to know?* *Would you like me to tell you all the details of your condition? If not, who would you like me to talk to?*
K	Knowledge of the condition	Provide the bad news or other information to the patient and/or family sensitively.	Do not just dump the information on the patient and family. Check for patient and family understanding. Possible phrases to use: *I feel badly to have to tell you this, but . . .* *Unfortunately, the tests showed . . .* *I'm afraid the news is not good . . .*
E	Empathy and exploration	Identify the cause of the emotions—e.g., poor prognosis. Empathize with the patient and/or family's feelings. Explore by asking open-ended questions.	Strong feelings in reaction to bad news are normal. Acknowledge what the patient and family are feeling. Remind them such feelings are normal, even if frightening. Give them time to respond. Remind patient and family you won't abandon them. Possible phrases to use: *I imagine this is very hard for you to hear.* *You look very upset. Tell me how you are feeling.* *I wish the news were different.* *We'll do whatever we can to help you.*
S	Summary and planning	Delineate for the patient and the family the next steps, including additional tests or interventions.	It is the unknown and uncertain that can increase anxiety. Recommend a schedule with goals and landmarks. Provide your rationale for the patient and/or family to accept (or reject). If the patient and/or family are not ready to discuss the next steps, schedule a follow-up visit.

Source: Adapted from R Buckman: *How to Break Bad News: A Guide for Health Care Professionals.* Baltimore, Johns Hopkins University Press, 1992.