HHS Public Access

Author manuscript

Nurse Pract. Author manuscript; available in PMC 2017 August 31.

Published in final edited form as:

Nurse Pract. 2012 February 12; 37(2): 1–4. doi:10.1097/01.NPR.0000408626.24599.9e.

Breaking bad news: A guide for effective and empathetic communication

Margaret Quinn Rosenzweig, PhD, FNP-BC, AOCNP [assistant professor]

University of Pittsburgh School of Nursing in Pittsburgh, PA

Abstract

Breaking negative news to patients is a common occurrence for nurse practitioners. This difficult task requires patience and refined communication skills, and must be approached with empathy for all parties involved. There are several ways to deliver bad news to patients successfully using patient-centered communication techniques and methods.

Keywords

empathetic communication; breaking bad news; patient-centered communication techniques

Well-developed communication skills are essential to providing optimal patient care. Communication skills for nurse practitioners (NPs) are worthy of evaluation and development as an important component in the provision of care.[1] Without excellent, empathetic communication skills, the NP is not able to fully relate to patients and families.

Patient-centered communication, regardless of provider, is a contributing factor to high-quality patient care. Most medical schools in the United States now offer a course in communication or have communication content integrated throughout the curriculum, regarding communication skills in healthcare. In fact, medical license exams require a demonstration of communication skills for medical practitioners.[2] In nursing schools, patient-centered communication techniques are taught didactally but like many new skills student nurses have the difficult task of integrating this content into clinical practice.[3] These skills need to be modeled and reinforced by faculty in clinical groups since communication is recognized as a competency for NPs that can improve patient outcomes.[4] The National Organization of Nurse Practitioner Faculty (NONPF), in their recently revised (2011) Nurse Practitioner Core Competencies, lists "provides patient-centered care recognizing cultural diversity and the patient or designee as a full partner in decision-making" as one of the competencies listed under Independent Practice competencies.[5]

As NP education evolves with the development of practice-focused doctoral programs, The American Association of Colleges of Nursing has published *The Essentials of Doctoral Education for Advanced Nursing Practice* in 2006.[6] Included is the requirement that nurses with the Doctor of Nursing Practice (DNP) "develop and sustain therapeutic relationships

The author has disclosed that she has no financial relationships related to this article.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

and partnerships with patients (individual, family or group) and other professionals to facilitate optimal care and patient outcomes."[6]

Delivering negative news

One of the most important components in the repertoire of NP communication skills is the ability to "break bad news" to patients and families. Many NPs view breaking bad news as a communication skill that is important for clinicians working in end-of-life care, where the news can be that treatment has been unsuccessful leaving few options for disease control, or that death is imminent. However, all healthcare providers break bad news on different levels with all types of patient populations.

Bad news can be understood as any information that changes a person's view of the future in a negative way.[7–9] The NP cannot judge what constitutes bad news and should be aware of this with any news that has the potential to alter an individual's view of themselves or their future.[8–10] NP practice does not regularly include the diagnosis of a life-ending illness, but often involves the communication of news that a new chronic diagnosis is present, that a chronic illness has worsened, or that attempts at management through medication or nonpharmacologic interventions have not been effective and that a new course of treatment is necessary.

Breaking bad news is a multifaceted task that can be managed successfully if it is done correctly. Many aspects of the interaction can be predicted, particularly if the patient is already in the NP's primary care practice or specialty practice. A mental strategy for not only conveying the information, but also dealing with the emotion, the family, and the plan for further care and support can be more easily planned when a relationship has previously been established with the patient. This process should be approached with concern for the patient and family receiving this news. Using a template or communication protocol while conveying bad news will help to instill and assure quality and empathy into this difficult communication process.

The SPIKES Protocol

Breaking bad news demands a great deal of professionalism, patience, and energy. This communication requires the twofold complex process of finding appropriate kind words and understandable terminology, and the secondary task of assessing how the patient and family are reacting, the degree of distress that the conversation is inducing, and the subsequent tailoring of information as the NP responds to the assessment process. The last segment of this communication is to move the patient and family from the bad news to the future plans with realism and hopefulness.

There are several accepted ways to break bad news. These methods include using common formats of structured listening to what the patient knows and wants to know, giving information in understandable amounts, reacting to the news, and checking for understanding.[8–10] The SPIKES Protocol[8–10] is a common template for breaking bad news that NPs can utilize as a starting place if they are unsure of how to proceed. Additionally, this is a task that often must be completed in the context of a busy clinical scenario, with less

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

than optimal time and conditions. Although all communication involving breaking bad news can not follow an exact protocol, the considerations of the SPIKES protocol can be helpful.[11] Many NPs find this standardized approach a helpful guide when initiating these difficult conversations.

The acronym SPIKES,[8–10] stands for **S**etting up, **P**erception, **I**nvitation, **K**nowledge, **E**motions with Empathy, and **S**trategy or Summary. This approach was designed by Walter Baile and colleagues at the University of Texas MD Anderson Cancer Center in Houston TX, and is designed to help healthcare professionals to accomplish the following while breaking bad news:

1. Establish an appropriate setting.
2. Check the patient's perception of the situation prompting the news regarding the illness or test results.
3. Determine the amount of information known or how much information is desired.
4. Know the medical facts and their implication before initiating the conversation.
5. Explore the emotions raised during the interview.
6. Respond with empathy.
7. Establish a strategy for support.[8–10]

Setting Up

The first step of the SPIKES protocol is setting up the interview. Setting the stage for optimal communication by preparing what to say prior to the conversation is essential to successful communication. The appropriate vocabulary to use and the information to be shared can also be reviewed ahead of the interview to assure that the NP feels prepared and less anxious. If the NP works in close collaboration with a physician, reviewing the news to be shared, the implications of the news, and the specific care plan is important. This step is particularly important for novice NPs working in collaborative practice agreements with a physician, unsure of what the collaborating physician may recommend in specific situations. A strong, unified, consistent message among all members of the healthcare team is essential.

Setting up also includes an attention to the physical space and the manner in which the news will be shared. The wrong physical setting for delivering negative news can lead to an unsuccessful discussion.[8–10] The rules of preferred body language for optimal communication including sitting while speaking, maintaining an open posture, and maintaining eye contact apply as the interview environment is considered. In a busy clinic, privacy may be less than optimal but every attempt should be made to provide a separate, quiet space during communication between the clinician, the patient, and the family. Asking the patient to quiet their personal communication technology prior to the conversation can also minimize distraction.[8–10]

It is important to eliminate evidence of nervousness; many clinicians feel anxious when sharing bad news with a patient. Reducing or eliminating body signals that illustrate

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

nervousness is very important in establishing rapport with the patient. Simply placing your feet flat on the floor with your ankles together and putting your hands, palms downward, on your lap is a successful neutral position. Maintaining eye contact with your patient will help ensure your attentiveness.[8–10]

Perception

The patient's perception of the news to be shared will determine how the news is conveyed to the patient. The NP must have a good assessment of what the patient and family know about the results of a test, what this news will mean to them in the context of the illness, and perhaps most importantly what they want to know. If the NP has a relationship with the patient and family and has been following the patient through a diagnostic workup or management of chronic illness, understanding the patient's perception of the news to be shared is relatively easy to assess. This becomes more difficult when this is a relatively new patient or one in which the NP has not been involved as a member of the care team.[8–10]

Empathic communication skills will help the NP explore the patient and family's perception of illness or events to date in a disease trajectory. The patient's response to the NP's questioning will help guide the manner and detail by which the details will be conveyed. Additionally, the NP can interpret if the patient is engaging in any variation of illness denial such as wishful thinking, omission of the essential but unfavorable medical details of the illness, or unrealistic expectations of treatment.[8]

The patient's denial behaviors are often important management strategies for the patient and family in dealing with overwhelming loss. The breaking of bad news should not shatter these important coping mechanisms.[8–10] The challenge for all clinicians is to respect the level of information desired, but have the patient and family know enough so that they are able to provide informed consent for further testing and treatment.

Invitation

The permission to have information shared is granted by the patient or family. Once an inquiry has been made as to the extent of understanding and the context in which the information fits, the NP can then ask for permission to share the current news. Using what the patient has shared about their understanding of the illness and the context in which testing has been done, the NP then asks permission to share the current information.[8–10]

Knowledge

The first step in actually delivering the news is to "Fire a Warning Shot" and warn the patient and family that the incoming news is not good.[8–10] Beginning a discussion with phrases such as: "Unfortunately I have some bad news to tell you," or "I am sorry to tell you," or "Things are not going in the direction we had hoped," allows the patient and family to emotionally brace themselves for the information to follow. These statements of warning also establish the NP as a patient advocate.

The sharing of bad news must be presented based on the assessed level of patient's understanding, compliance, and wishes for disclosure. Instead of using technical language,

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

showing patients concrete examples of trends in lab work or radiology can make an abstract concept clearer. The actual sharing of the bad news should be done slowly so that the patient and family understand. Choosing words carefully is particularly important if the news indicates a very poor prognosis. These conversations and choice of words on the part of the clinician can be vital as the patient and family deal with the news in the upcoming days and weeks. The heightened emotion in these conversations underscores the need for mental and emotional preparation prior to the patient interaction.

In situations involving cancer, patients report that the most important component of the process of breaking bad news is the content itself, specifically the expertise and the specific detail that is provided during the conversation. This demands that the NP be well prepared for the informational needs of the patient and family.[12]

Empathy

Patients will have a wide range of emotional reactions as they respond to the bad news delivered to them. The emotional response may range from silence to dramatic crying and sobbing. This creates a potentially awkward situation for the NP, but this sense of awkwardness can be diminished through engaging in empathetic communication. Although the entire conversation and time spent interacting with the patient involves empathetic communication, an appropriate and kind response to the emotion demonstrated when the patient hears bad news is critically important. The NP should show an understanding of the patient's emotion and demonstrate empathy and respect in the face of a difficult situation.[13,14]

Strategizing for the future

The last step in the SPIKES Protocol, will be to establish that patients have a clear plan for the future.[7–9] Preparatory information is important in order to decrease distress, regardless of illness stage. One of the best ways to prepare a patient for participation in treatment decisions is to ensure that he or she understands the information that has been provided. Before discussing a treatment plan, it is important to ask your patient if they are ready for such a discussion. Frequent clarification during the discussion of the treatment plan will help the NP establish the patient's understanding and likelihood of following through with the plan.[15,16]

At the conclusion of the discussion, both the NP and the patient should leave with a clear plan of the steps that need to be taken and the roles each will play in taking those steps. If further testing is needed, the tests should be arranged and the patient should have a clear understanding of how those results will be communicated.[8–10]

Refining communication skills

There is a general consensus that these skills are important to the NP and can be taught in any NP program curriculum. Placement in a physical assessment course or differential diagnosis course matches the student learning needs as they encounter this content. While communication content has a cognitive component, communication skills such as breaking bad news for healthcare providers should ideally be taught using an experiential and not just

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

a didactic methodology. A skill such as breaking bad news is ideally taught as a psychomotor skill with didactic content presented initially, an opportunity for the student to "practice" in a controlled setting, and then an opportunity to utilize these skills in a precepted clinical setting.[17–19]

Conclusion

Breaking bad news is an important clinical skill that can be frequently utilized in the context of routine practice. Following an established protocol while integrating empathetic communication makes the difficult task of breaking bad news more comfortable for the NP and helps improve the communication between the patient and family. These skills can be learned in continuing education programs or easily integrated into NP curriculum.[20]

References

1. Berry JA. Nurse practitioner/patient communication styles in clinical practice. J Nurse Pract. 2009; 5:508–515.
2. Scoles PV, Hawkins RE, LaDuca A. Assessment of clinical skills in medical practice. J Contin Educ Health Prof. 2003; 23(3):182–190. [PubMed: 14528790]
3. Aled J. Putting practice into teaching: an exploratory study of nursing undergraduates' interpersonal skills and the effects of using empirical data as a teaching and learning resource. J Clin Nurs. 2007; 16(12):2297–2307. [PubMed: 18036120]
4. Charlton CR, Dearing KS, Berry JA, Johnson MJ. Nurse practitioners' communication styles and their impact on patient outcomes: an integrated literature review. J Am Acad Nurse Pract. 2008; 20(7):382–388. [PubMed: 18638178]
5. National Organization of Nurse Practitioner Faculties. Nurse Practitioner Core Competencies. http://www.nonpf.com/displaycommon.cfm?an=1&subarticlenbr
6. American Association of Colleges of Nursing. [Published October 2006] The Essentials of Doctoral Education for Advanced Practice Nursing. http://www.aacn.nche.edu/DNP/pdf/Essentials.pdf
7. Buckman, R. Breaking Bad News: A Guide for Health Care Professionals. Baltimore: Johns Hopkins University Press; 1992. p. 65-97.
8. Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES—a six-step protocol for delivering bad news: application to the patient with cancer. Oncologist. 2000; 5(1):302–311. [PubMed: 10964998]
9. Buckman RA. Breaking bad news: the S-P-I-K-E-S strategy. Psychosoc Oncol. 2005; 2(2):138–142.
10. McFarlane J, Riggins J, Smith TJ. SPIKES: a six-step protocol for delivering bad news about the cost of medical care. J Clin Oncol. 2008; 26(25):4200–4204. [PubMed: 18757335]
11. Eggly S, Penner L, Albrecht TL, et al. Discussing bad news in the outpatient oncology clinic: rethinking current communication guidelines. J Clin Oncol. 2006; 24(4):716–719. [PubMed: 16446346]
12. Parker PA, Baile WF, deMoor C, Lenzi R, Kudelka AP, Cohen L. Breaking bad news about cancer: patients' preferences for communication. J Clin Oncol. 2001; 19(7):2049–2056. [PubMed: 11283138]
13. Kaakinen J, Shapiro E, Gayle BM. Strategies for working with elderly clients: a qualitative analysis of elderly client/nurse practitioner communication. J Am Acad Nurse Pract. 2005; 13(7): 325–329.
14. Branch WT, Kern D, Haidet P, et al. Teaching the human dimension of care in clinical settings. JAMA. 2001; 286(9):1067–1074. [PubMed: 11559292]
15. Mackillop WJ, Stewart WE, Ginsberg AD, Stewart SS. Cancer patients' perceptions of their disease and its treatment. Br J Cancer. 1988; 58(3):355–358. [PubMed: 2460120]
16. Quirt CF, McKillop WJ, Ginsberg AD, et al. Do doctors know when their patients don't? A survey of doctor-patient communication in lung cancer. Lung Cancer. 1997; 18(1):1–20.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

17. Fallowfield L, Jenkins V, Farewell V, Saul J, Duffy A, Eves R. Efficacy of a Cancer Research UK communication skills training model for oncologists: a randomized controlled trial. Lancet. 2002; 359(9307):650–656. [PubMed: 11879860]
18. Wilkinson SM, Leliopoulou C, Gambles M, Roberts A. Can intensive three-day programs improve nurses' communication skills in cancer care? Psychooncology. 2003; 12(8):747–759. [PubMed: 14681949]
19. Maguire P, Pitceathly C. Key communication skills and how to acquire them. BMJ. 2002; 325(7366):697–700. [PubMed: 12351365]
20. Rosenzweig M, Hravnak M, Magdic K, Beach M, Clifton M, Arnold R. Patient communication simulation laboratory for acute care nurse practitioner students. Am J Crit Care. 2008; 17(4):364–372. [PubMed: 18593836]