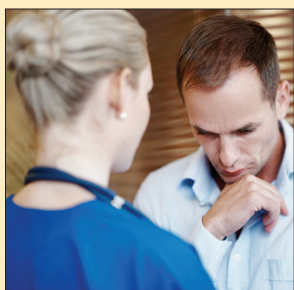


■ Online Exclusive CNE Article/Journal Club

Improving Oncology Nurses' Communication Skills for Difficult Conversations

Linda Baer, MSN, NP-C, OCN®, and Elizabeth Weinstein, MD, MS



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When oncology nurses have strong communication skills, they play a pivotal role in influencing patient satisfaction, adherence to plans of care, and overall clinical outcomes. However, research studies indicate that nurses tend to keep communication with patients and families at a superficial, nontherapeutic level. Processes for teaching goals-of-care communication skills and for implementing skills into clinical practice are not clearly defined. Nurses at a large comprehensive cancer center recognized the need for help with this skill set and sought out communication experts to assist in providing the needed education. An educational project was developed to improve therapeutic communication skills in oncology nurses during goals-of-care discussions and giving bad news. The program was tailored to nurses and

social workers providing care to patients in a busy, urban, academic, outpatient oncology setting. Program topics included exploring the patient's world, eliciting hopes and concerns, and dealing with conflict about goals. Sharing and discussing specific difficult questions and scenarios were encouraged throughout the program. The program was well attended and well received by oncology nurses and social workers. Participants expressed interest in the continuation of communication programs to further enhance skills.

Linda Baer, MSN, NP-C, OCN®, is a nurse practitioner at University Hospitals Case Medical Center and Elizabeth Weinstein, MD, MS, is the medical director of Supportive Oncology Services at University Hospitals Seidman Cancer Center and an assistant professor in the School of Medicine at Case Western Reserve University, all in Cleveland, OH. The authors take full responsibility for the content of the article. The authors did not receive honoraria for this work. The content of this article has been reviewed by independent peer reviewers to ensure that it is balanced, objective, and free from commercial bias. No financial relationships relevant to the content of this article have been disclosed by the authors, planners, independent peer reviewers, or editorial staff. Baer can be reached at linda.baer@uhhospitals.org, with copy to editor at CJONEditor@ons.org. (First submission June 2012. Revision submitted August 2012. Accepted for publication September 12, 2012.)

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Nurses can directly impact the care of patients and their families through the use of therapeutic communication (Wilkinson, Gambles, & Roberts, 2002). Communication skills between a healthcare provider and a patient can be defined as the specific behaviors and responses used in a therapeutic relationship (Kennedy Sheldon, 2005).

Communication influences factors such as patient satisfaction, anxiety, medication adherence, and clinical outcomes (Eid, Petty, Hutchins, & Thompson, 2009; Tobin & Begley, 2008). Patients and families want clear information regarding the disease process, prognosis, symptom management, treatment options, and end-of-life care in a way that allows patients to finalize affairs and say goodbye to loved ones, if necessary (Betcher, 2010; Parker et al., 2007). In addition, patients and families prefer the style of communication to include empathy and honesty, balanced with sensitivity and hope (Parker et al., 2007). According to Epstein and Street (2011), a high-quality

outcome is providing a partnership approach to patient care that values patient preferences.

Patient-centered care is one of the six key elements of high-quality care as described in the Institute of Medicine's (IOM, 2001) *Crossing the Quality Chasm: A New Health System for the 21st Century*. The report challenges healthcare providers to strive for a partnership with patients that incorporates respect, solidarity, and empathy. By using complex communication skills, the nurse is able to incorporate the quality-of-life domains (physical, psychological, social, and spiritual aspects) to address patient care needs (IOM, 2001).

Many nursing programs do not teach difficult communication skills such as giving bad news or responding to difficult questions (e.g., "Am I dying?"). Nurses need to be taught how to respond to these difficult questions and how to communicate effectively with patients with cancer and their families about treatment options and how they relate to goals of care. A goals-of-care conversation has all the qualities described in patient-centered care. The

patient's values, preferences, worries, and fears are incorporated into the treatment path to be taken in light of serious illness. Traditionally, physicians have been responsible for these difficult conversations; however, with the advancement of nursing practice, nurses are now taking the lead (IOM, 2011). Realizing the importance of the role of the nurse in difficult conversations with patients and families, this article discusses an educational series developed to engage nurses and promote self-efficacy in the advancement of their own therapeutic communication skills. The overarching goal of the series was to positively impact the care of patients with enhanced communication techniques.

Processes for Improving Therapeutic Communication

The IOM's report, *Approaching Death: Improving Care at the End of Life*, identified inadequate knowledge and education of healthcare professionals in palliative care skills, including effective communication techniques (Field & Cassel, 1997). Processes for improving communication skills regarding goals of care and delivering bad news are not clearly defined (Johnston & Smith, 2005). Various training methods include didactic methods, video demonstration, discussion, feedback training, use of simulated patients, and role playing. According to a review of research studies about communication skills training with physicians, oncologists, nurses, and healthcare providers, content across the programs included use of open-ended questions, empathetic statements, and response to patient cues (Kennedy Sheldon, 2005). One educational approach to improve communication skills is introduction of content, followed by continuous skills assessment and mentored feedback (Rosenzweig, Clifton, & Arnold, 2007). Small group teaching has been effective for teaching complex communication skills to assist the healthcare provider (Fryer-Edwards et al., 2006; Wilkinson, Roberts, & Aldridge, 1998). Completed nursing studies note that demonstrating a sustained impact of communication skills training on nurses' clinical practice can be challenging (Eid et al., 2009). To keep improving skills, ongoing workshops and education in communication techniques have been shown to be important (Kennedy Sheldon, 2005).

Communication in the Oncology Nursing Setting

Relevance of communication skills training in cancer nursing care is not questioned. Feedback has been obtained from patients and families through open-ended interviews, surveys, and focus groups regarding their experiences. Areas of concern included symptom management, involvement in treatment decisions, and being treated as a whole person. Patients also wished to remain mentally alert, avoid needless prolongation of dying, and retain a sense of control over the dying process (Parker et al., 2007). Although patients and family members say they want that information, they may be reluctant to initiate such discussions (Dahlin, 2010). In the oncology setting, communication can be complicated by patient and family perceptions, expectations, previous experiences, emotional state, and disease course (Kennedy Sheldon, 2005). Facilitating, exploring, and validating socioemotional concerns can decrease anxiety and distress in the face of a

life-threatening condition. Nurses witness and respond to suffering and advocate for patients and families (Ferrell & Coyle, 2008). Oncology nurses have the opportunity to positively impact patients, particularly those in the terminal phase of cancer (Coyne et al., 2007).

Communication Training and Physicians

In the past, a more paternalistic approach was taken in the health care of patients (Eid et al., 2009). The current emphasis is on patient autonomy and empowerment. Historically, physicians bore the responsibility of delivering news about diagnosis, treatment, and prognosis. For a variety of reasons, physicians often do not include the nurse in the delivery of bad news to patients, which can lead to avoidance of goals of care discussions and unwillingness to disclose health information by the nurse because of uncertainty of the care plan. Programs have been developed to improve physician communication skills, but few studies have determined the efficacy of communication skills training for physician trainees at the behavioral level (Back et al., 2007). One example of a training program for oncology fellows and physicians is Oncotalk[®]. This program is presented in a four-day retreat format and includes presentations, role-playing, practice, and reflection to enhance communication skills (Back et al., 2007).

Communication Training and Nurses

Unfortunately, information is lacking about end-of-life care in undergraduate and graduate nursing curricula in the United States (Coyne et al., 2007; Ferrell, Virani, & Grant, 1999). Efforts are underway to improve end-of-life care in academic programs (Coyne et al., 2007; Ferrell et al., 1999; Rosenzweig et al., 2007). However, that will not help currently practicing nurses. In 1997, recognizing the importance of communication, the American Association of Colleges of Nursing identified a competency for end-of-life care that requires nurses to communicate effectively and compassionately with patients, families, and the healthcare provider team. To help address gaps in preparing nurses to have these conversations, the End-of-Life Nursing Education Consortium (ELNEC) collaborated with the Oncology Nursing Society in 2000 to develop a national education initiative to improve end-of-life care in the United States. The project provides nursing faculty, continuing education providers, staff development educators, and clinical nurses with training in end-of-life care so that they can teach the program to students and practicing nurses (Coyne et al., 2007). The program includes communication as one of the nine modules.

Barriers to Therapeutic Communication

Several studies indicate that nurses tend to keep communication at a superficial level and avoid emotional cues (Clarke & Ross, 2006; Kvåle, 2007). Many barriers exist to employing effective communication techniques. Various demands in a clinical setting and lack of time further impact patient and nurse discussions. According to one study, healthcare providers acknowledged 57% of socioemotional cues, but only explored 22% of those cues (Kennedy Sheldon, Hilare, & Berry, 2011). Being unsure of ways to proceed with patients in light of their

TABLE 1. SPIKES and Ask-Tell-Ask Models

Step	What to Do
1. Getting the setting right	Choose a setting with privacy and without interruptions. <ul style="list-style-type: none"> • Find out if the patient wants other(s) present. • Confirm medical facts. • Plan what you will say. • Think about your own emotional reaction to giving the news.
2. Patient perception , ASK (#1)	What does the patient know? <ul style="list-style-type: none"> • Sometimes patients give or already know the bad news. Consider open-ended questions.
3. Invitation	Find out what the patient wants to know. Find out what the patient already knows. Explore how much detail the patient would like. Consider cultural variation. Allow the patient to decline voluntarily to receive information. Allow the patient to designate someone to communicate on his or her behalf. Give the patient control over hearing the news.
4. Giving knowledge , TELL	Foreshadow Prepare for bad news. Say it—then stop. Provide clear, patient-specific information. Avoid jargon. Provide small bits of information. Pause frequently. Check for understanding. Use silence and receptive body language.
5. Addressing emotions , ASK (#2)	Anticipate emotional reactions. Resist the temptation to try to make the bad news better than it is. Employ techniques to respond to patient emotions. Use NURSE statements (Back et al., 2005) <ul style="list-style-type: none"> • Name an emotion, any emotion. • Understand fears, concerns, and other emotions. • Respect patient's experiences, emotions. • Support; continue to help the patient, identify resources • Explore; clarify
6. Summary and strategy	Ask about the patient's concerns and fears. <ul style="list-style-type: none"> • What are your concerns? Do you want to talk about them? Plan for next steps (e.g., tests, treatment).

Note. Based on information from Back et al., 2009; Kaplan, 2010.

hopes and concerns may lead to nurses using blocking behaviors, such as changing the subject or ignoring cues. Nurses may use defense mechanisms to protect themselves from the emotions of patients and families because of a lack of confidence in their ability to address those emotions (Betcher, 2010).

Nurses have become more accustomed to focusing on concrete physical aspects of care (Rask, Jensen, Anderson, & Zachariae, 2009). Nurses often communicate with patients and families in the form of education and support. Traditionally, the nurses' tasks include assessing the patient, administering treatments, and providing comfort to patients and families while in the clinic (Rask et al., 2009). However, inadequate communication skills can lead to negative effects for the nurse, as well, including burnout, low personal accomplishment, cynicism, and emotional exhaustion (Ramirez et al., 1995). Inaccurate assessment of patient distress

occurs when values are not explored and uncomfortable topics are diverted (Baile et al., 2000).

Development of a Communication Program

The ELNEC program is a requirement for all oncology nurses at the authors' institution. To keep advancing communication skills regarding end-of-life care at the forefront, a communication series was developed at the large academic medical center where the authors work. The program development team included a nurse educator, an outpatient staff nurse, and a palliative care physician with extensive training in teaching communication skills regarding end-of-life care. A series of three one-hour sessions, scheduled one month apart, were outlined to cover the content of giving bad news and discussing goals of care. The palliative care physician and oncology nurse worked to tailor the content to make it meaningful for the audience of nurses and social workers. The program was supported by the administration and paid time was given to attendees. The sessions were advertised via e-mail and flyer postings. Inpatient and outpatient nurses and social workers were invited to attend.

The sessions were presented to nurses and social workers at the main campus as well as satellite locations via video conferencing. In addition, the programs could be accessed on the institution's electronic Learning Management System for those unable to attend the sessions. Social work and nursing contact hours were awarded for each session. Attendance was voluntary and participants were not required to attend all three sessions. Recognizing that attending educational programs during a busy inpatient or outpatient shift is a challenge, the presentations were scheduled from 7–8 am.

The sessions began with a brief PowerPoint® presentation of the importance of strong communication skills. Included in that didactic were descriptions of deficits in communication skills and techniques to enhance skills. The goal of this format included participation and interaction by the attendees throughout the program. The topics of the presentations incorporated some general communication skills content, giving bad news, and goals of care with specific pearls and pitfalls. Evaluations regarding demographics and skills were completed after each session. In particular, each participant rated their perceived level of skill prior to and following the session.

Exploration on the Go



MD Anderson Cancer Center offers healthcare providers information about the SPIKES protocol and videos to show it in action. To access, open a barcode scanner on your smartphone, take a photo of the code, and your phone will link automatically. Or, visit <http://bit.ly/14K49Nz>.

- ▶ What is the hardest part of what is going on with you and your family?
- ▶ “Tell me more” (functions as an invitation)
- ▶ “What bothers you most?” can elicit a wide variety of patient concerns.
- ▶ What is most important to you if your time is limited?
- ▶ What is your life like outside of the hospital or clinic?
- ▶ What do you enjoy?
- ▶ How can we help you do more of this?
- ▶ When you think of the future, what concerns you most?

FIGURE 1. Questions to Explore a Patient’s World

Program Content and Teaching Strategies

Class 1: General Communication Skills and Giving Bad News

Objectives

- Define SPIKES, a six-step protocol for giving bad news.
- State general communication techniques of Ask-Tell-Ask and Tell-Me-More.
- Define the NURSE mnemonic for verbal empathetic responses to emotion.

“The more that nurses are responsible for patient care in oncology, the more it seems necessary to train them in breaking bad news” (Langewitz et al., 2010, p. 2,267). Nurses are in a position to deliver bad news when helping patients to explore treatment choices, validating worsening disease or condition, and discussing end-of-life wishes (Malloy, Virani, Kelly, & Munevar, 2010; Radziewicz & Baile, 2001). Bad news is defined as “any news that drastically and negatively alters the patient’s view of his or her future” (Buckman, 1992, p. 15). Nurses should recognize that giving bad news is a process that often occurs over a period of time (Tobin & Begley, 2008). By understanding that giving bad news is a process, nurses need to realize their role as patients and families assimilate the meaning of the bad news.

SPIKES is an acronym (setting, patient perception, invitation, knowledge, emotions, summary and strategy) for a six-step protocol for presenting distressing information in an organized fashion (Back, Arnold, & Tulskey, 2009; Kaplan, 2010) (see Table 1). The goal of a conversation using the steps in SPIKES is to gather information from the patient and family, provide medical information, and support the patient and family (Baile et al., 2000). This protocol can be further simplified to Ask-Tell-Ask by asking the patient and family what they know and understand, telling the patient medical information, and asking about patients’ emotions (Back et al., 2009). NURSE is an acronym (name, understand, respect, support, explore) representing a method of responding to patients’ emotions with empathy (Back, Arnold, Baile, Tulskey, & Fryer-Edwards, 2005; Smith & Hoppe, 1991). Only using one of the options in the NURSE acronym is necessary to effectively respond to emotion.

If untrained in communication, nurses may find it easier to avoid the discussion of a worsening patient condition than to address it. Through the avoidance of such news, the nurse may be offering false hope and less realism. Nurses need to be equipped to give bad news skillfully because patients may want to know. Through honesty and empathic communication, the patient and nurse relationship is strengthened. Patients and families often need simple explanations to understand complex medical

terminology and language. With the appropriate knowledge, patients and families have the opportunity to cope with the news and make plans. When these conversations are conducted effectively, psychosocial morbidity (e.g., anxiety, depression) decreases (Kennedy Sheldon et al., 2009).

Pitfalls in communication occur when assumptions are made about what the patient and family understand and want to know. By trying to minimize the impact of the bad news, an opportunity to help the patient and family cope and plan may be missed. Answering emotions with fact also is common. An emotional response could be when a patient states, “I cannot believe my kidneys are failing.” When nurses answer with facts about the spread of cancer, they are not cluing in to the feeling behind the statement. An empathic response may be more appropriate.

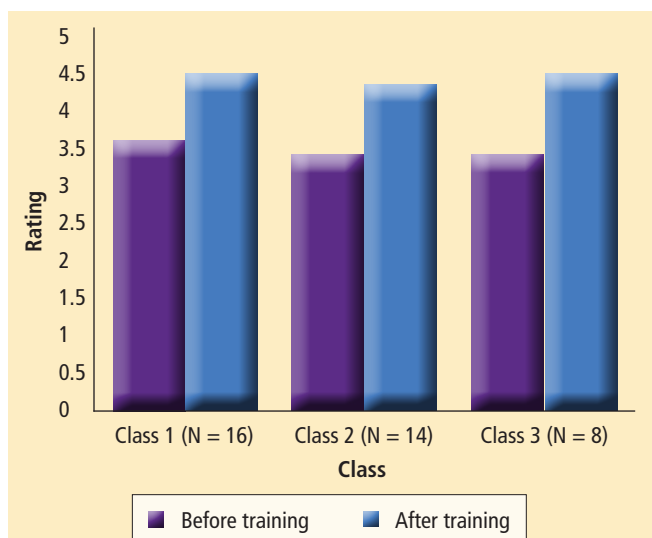
Nurses can avoid these pitfalls by recognizing that a step-wise approach has value and acknowledging that they can’t make it better than it really is. It seems reasonable to understand that patients routinely get upset when they hear bad news. Communication techniques that support the patient can reduce nurse and patient stress (Kennedy Sheldon et al., 2009). By learning responses to several common dreaded questions, nurses can increase their confidence in having such discussions.

Class 2: Goals of Care

Objectives

- Name at least two questions that can be used to elicit patient values for goals of care conversations.
- Identify conflicts around goals of care and how to approach them.
- State general responses to commonly asked “dreaded questions.”

Giving bad news and discussing goals of care are similar in the respect that the conversation feels bad. Significant uncertainty



Note. The mean years of oncology experience for the sample was 25.9 years.

Note. The rating scale ranged from 0 (no skill) to 5 (expert skill).

FIGURE 2. Average Ability to Meet Objectives for Each Class, Before and After Training

- ▶ End-of-Life Nursing Education Consortium
www.aacn.nche.edu/el nec
- ▶ Hospice and Palliative Nurses Association
<http://nurseslearning.com/catalog.cfm?Topic=40%20>
- ▶ Medical College of Wisconsin End of Life/Palliative Education Resource Center
www.eperc.mcw.edu/Eperc/FastFactsandConcepts
- ▶ Oncotalk®
www.depts.washington.edu/oncotalk/

FIGURE 3. Resources for Additional Communication Education

often surrounds a patient’s medical condition. Uncertainty also exists regarding what kind of reaction the patient and family will have to the news or conversation. In addition, the likelihood that patients and families will resist this type of discussion is unknown. By discussing goals of care, the patient or surrogate can make some decisions and plan for the future based on the patient’s values. Resistance to hearing bad news and discussing goals of care may stem from either the belief that patients and families do not understand the patient’s condition or they understand and they disagree with what medical providers are offering them. In addition, disagreement or conflicting information may be given regarding the plan of care, further confusing the patient and family.

If a patient has a particular hope aimed at a precise goal, it may be feasible to find a way to meet this goal. Generalized hope simply serves to protect one’s integrity (Daneault et al., 2010). False hope may lead to the neglect of final arrangements and add to family burden (Daneault et al., 2010). Therefore, sorting out what is realistic as opposed to unrealistic hope is important (Gadgeel, 2011). When a patient or family hopes for a miracle, a wish statement may be an effective response. A wish statement is a cognitive response that says “I hope for what you hope for” while implicitly acknowledging that it may be an unlikely outcome (Casarett & Quill, 2007). A plan to hope for the best and plan for the worst may be a way to respond to hope for a miracle (Back, Arnold, & Quill, 2003). Although that may sound contradictory, it may be an effective way to align with a patient and family. The approach may include two types of coaching: optimism (e.g., “Let’s hope”) and realism (e.g., “Let’s prepare”) (Back et al., 2003). Internal questions nurses should be asking themselves and using to negotiate with the patient and family may include: Can you come up with a time-limited trial? Can we find a common goal to work on? (see Figure 1).

Nurses dread questions such as, “Am I dying?” However, such cognitive questions deserve answers and are emotional statements that need attention. Pearls to eliciting hopes and concerns are to invite the conversation and not force it. Remember to acknowledge the loss. Reaffirming commitment to the patient and family may provide some comfort in the face of a change in goals (e.g., palliation instead of cure). Pitfalls to avoiding goals-of-care discussions may be to respond to distress with more treatment. Addressing code status before exploring the big picture may not allow patients and families to understand the consequence of their decisions.

Class 3: Difficult Conversations

Objectives

- Review Ask-Tell-Ask and NURSE communication techniques.
- Review ways to deal with conflict over goals.
- Review appropriate responses to commonly asked “dreaded questions.”

The purpose of the third class in this series was to review general communication techniques of Tell-Me-More, Ask-Tell-Ask, SPIKES, and NURSE methods. Time was available for discussion and questions. In addition, the class discussed suggestions in the presence of conflict over goals of care.

Post-Program Evaluations

The program was well attended by nurses and social workers, most of whom were very experienced, as reflected in the post-program surveys of communication skills. On a scale ranging from 0–5, on average, nurses and social workers felt their skill level was about 4.5 after training, as opposed to 3.5 before the training. Overall, the evaluations were positive. Most participants felt the content of the presentations and the interactive discussions were a step forward in improving their communication skills, as evidenced by post-survey scores (see Figure 2). These presentations have laid the ground work for future efforts to enhance communication skills of nurses and social workers in the authors’ oncology setting. More practice time and less didactic time will aid in skill development.

Recommendations for Oncology Practice

By acknowledging that healthcare providers often miss cues or underestimate the desire of patients and families to discuss end-of-life issues, a patient tool may be beneficial. To assist patients and families in having these meaningful talks, a question prompt list for the nurse may be a useful guide (Clayton et al., 2007). In addition, implementing a curriculum with practice sessions and immediate feedback in a small group setting is a key component to help increase the skill and confidence of nurses to have these discussions. Regular team conferences, family meetings, and psychosocial rounds are additional strategies to improve communication and patient-centered care. See Figure 3 for more resources for communication education.

Conclusion

Communication is a basic survival skill and one of the most challenging responsibilities of a healthcare provider (Eid et al.,

Implications for Practice

- ▶ Ongoing education for healthcare professionals can improve communication skills in difficult conversations.
- ▶ Healthcare professionals should identify expert resources to further assist with the development of communication skills.
- ▶ Real-time debriefing of particularly challenging patient situations can enhance the team’s communication skills.

2009). Like nursing, communication is also an art and a skill. Improving communication skills takes time, practice, persistence, and reflection on the part of each individual nurse. Conducted well or not, interactions will be remembered by the patient and family (Radziewicz & Baile, 2001; Virani, Malloy, Ferrell, & Kelly, 2008). The authors' tailored communication series was an introduction of this content to determine the interest and self-perceived skill level of our nurses to plan for future programs. Nurses should advocate for the interactive education needed to enhance this skill. Better communication, through knowledge, support, experience, and success, may increase confidence and self-efficacy, which ultimately improves patient-centered care.

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