

Breaking Bad News

An evidence-based review of communication models for oncology nurses

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BACKGROUND: A diagnosis of cancer is a stressful, difficult, and life-altering event. Breaking bad news is distressing to patients and families and is often uncomfortable for the nurse delivering it. Evidence-based communication models have been developed and adapted for use in clinical practice to assist nurses with breaking bad news.

OBJECTIVES: The purpose of this article is to provide an overview on breaking bad news and to review the utility of the SPIKES and PEWTER evidence-based communication models for oncology nurses.

METHODS: Perceptions of breaking bad news from the nurse and patient perspectives, as well as barriers and consequences to effective communication, will be presented. Clinical examples of possible situations of breaking bad news will demonstrate how to use the SPIKES and PEWTER models of communication when disclosing bad news to patients and their families.

FINDINGS: By using the evidence-based communication strategies depicted in this article, oncology nurses can support the delivery of bad news and maintain communication with their patients and their patients' families in an effective and productive manner.

KEYWORDS

patient-provider communication; breaking bad news; evidence-based practice

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EVER SINCE THE MEDICAL ONCOLOGY TEAM RECEIVED the patient's test results, the nurse has been struggling with how to support the patient while receiving and following the disclosure of bad news. Recent scans revealed that the patient's breast cancer has metastasized to her bones. The nurse and the oncologist have been managing the patient's cancer for the past two years, and the nurse is tormented knowing that the patient is going to be devastated with the news of her cancer progression. The oncologist will break the bad news to the patient, and the nurse anticipates the need for ongoing support and information. The nurse initially feels unprepared to have this difficult conversation.

About 117 million people in the United States are diagnosed with chronic health conditions, such as heart disease, cancer, arthritis, and diabetes (Centers for Disease Control and Prevention, 2017). Serious chronic or life-threatening illnesses often require that the patient or the patient's family are made aware of the diagnosis. The approach used to deliver the bad news of a diagnosis is important and requires preparation and knowledge of techniques helpful for delivering potentially distressing information. This article provides an overview of breaking bad news and case studies of breaking bad news situations for oncology nurses using the SPIKES (Baile et al., 2000) and PEWTER (Keefe-Cooperman & Brady-Amoon, 2013) evidence-based models of communication. This article describes breaking bad news from the perspectives of patients with cancer and oncology nurses, discusses the consequences of ineffective communication, introduces models of practice, and provides examples of effective communication. Evidence-based practice suggestions for oncology nurses to build confidence in communicating distressing information will also be offered.

Definition of Breaking Bad News

In terms of health care, bad news is considered any information that changes a patient's view of the future in a negative way (Buckman, 1984; Rosenzweig, 2012). Generally, breaking bad news is when the diagnosis is shared with the patient; however, it can also include the communication of a new chronic diagnosis or information that a chronic disease has worsened (Rosenzweig, 2012). Bad news can be a personal perception, which makes it difficult to anticipate the individual impact and consequences of distressing information on the patient and his or her family (Ptacek & Eberhardt, 1996).

Although some published research demonstrates how to proceed when faced with the task of delivering bad news, little research exists that focuses

specifically on best practice for oncology nursing. Unlike guidelines for the management of hypertension (James et al., 2014) or type 2 diabetes (Handelsman et al., 2015), best practice guidelines for how nurses should deliver bad news and provide support to their patients are limited. Much of the published research, curriculum, and training for breaking bad news is targeted to physicians and medical residents; however, the current literature serves as a foundation for how to approach breaking bad news in nursing practice (Breaking Bad News Foundation, 2016).

The Nurses' Experience

Many peer-reviewed publications highlight the importance of communication technique when delivering bad news to patients with cancer and their family members (Bousquet et al., 2015; Rao, Ekstrand, Heylen, Raju, & Shet, 2016; Repetto, Piselli, Raffaele, & Locatelli, 2009; Richter et al., 2015). A study by Paul, Clinton-McHarg, Sanson-Fisher, Douglas, and Webb (2009) evaluated education programs that focused on the communication techniques associated with breaking bad news. Despite the amount of information available, many nurses and clinicians perceive a lack of adequate training in communicating bad news to patients and families in their practice settings (Al-Mohaimed & Sharaf, 2013; Ptacek & Ellison, 2000).

After the provider initially relays information about the patient's diagnosis or disease progression, nurses are usually the members of the healthcare team who provide ongoing support to the patient and family members. Understanding the efficiency of the breaking bad news conversation, the specific concerns of the patient and family, and how the information is received are important in providing continued support and education. Patients and families often turn to the nurse for clarification and additional information or to redeliver the bad news. When breaking bad news is ineffective or insensitive, the oncology nurse can provide support for any emotional trauma that may occur (Aungst, 2009).

In palliative care, breaking bad news is often associated with discussions of cancer progression, time of survival, and situations such as actively dying as opposed to the news of an initial diagnosis or prognosis. A trusting relationship between the nurse and the patient is extremely important for effective communication (Mishelovich, Arber, & Odelius, 2016). Discussions concerning ending curative treatment and reestablishing plans for palliative treatment are part of the nurse's role (Hollyday & Buonocore, 2015). Breaking bad news discussions may have to occur frequently in an effort to help patients and family members understand the aspects of palliative care.

In situations concerning the withdrawal of life-sustaining treatment, where the patient may be unconscious or otherwise unable to communicate independently, breaking bad news focuses on family caregivers or loved ones. Nurses must be aware of the complexities of communication that can help families cope with

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the difficult situation or decision (Bloomer, Endacott, Ranse, & Coombs, 2017). Emotional care and support of the family requires not only the initial bad news discussion on ending life-sustaining treatment, but also continued preparation for reiterating what to expect as the patient enters an actively dying phase of life (Ranse, Bloomer, Coombs, & Endacott, 2016). Breaking bad news is generally not a onetime event, and nurses must work with families to process the difficult information and provide clarification as needed (Warnock, 2014). From 2006–2012, full disclosure of life expectancy at end of life increased (Ichikura et al., 2015), creating a need for more breaking bad news encounters. Communication must be uninterrupted and delivered with mindfulness to allow the listener to process the end of life and eventual death of a loved one (Guest, 2016).

The Patient Experience

According to Fujimori et al. (2007), patients want the opportunity to discuss their diagnosis and care management plans with their family, and most patients want their family included in the initial conversation. However, many patients believe that they should receive the initial news directly from the healthcare team and not from family members (Aminiahdashti, Mousavi, & Darzi, 2016). A study by Rao et al. (2016) demonstrated that some patients with cancer, particularly men, prefer full disclosure concerning their prognosis and diagnosis, with Seifart et al. (2014) concluding that less than half of male patients report being satisfied with the breaking bad news encounter. Research suggests that, as long as the information is accurate (Repetto et al., 2009), patients prefer and expect full disclosure even if the information being shared is negative, stressful, or extremely worrisome (Tuckett, 2004). However, Rao et al.'s (2016) study indicated that a smaller percentage of patients do not wish to know the details of

their malignancy, which can be because of the timing of the news, the approach of the provider giving the diagnosis, or the presence of family members.

In a study of older patients with cancer, aged 70–89 years, less than half wanted information on survival and about half wanted a passive role in the decision-making process concerning treatment (Elkin, Kim, Casper, Kissane, & Schrag, 2007). However, in a general study comparing young, middle-aged, and older adult patients with cancer, no differences were found between communication preferences and the content of bad news (Richter et al., 2015).

Cultural Considerations

Across all cultures, patients generally prefer an experienced provider who is empathic and caring, offers hope, and uses the correct wording for difficult conversations (Martins & Carvalho, 2013) to communicate bad news (Aminiahidashti et al., 2016). Patients who do not tend to be satisfied with a difficult conversation report a pessimistic or unsympathetic manner of the teller (Martins & Carvalho, 2013). Patients, particularly men, rate honesty as the most important feature of communication, followed by the expertise of the provider delivering the bad news and the type and extent of treatment information given (Davison, Parker, & Goldenberg, 2004).

Many cultures express preferred differences in the delivery of bad news. In China, it is frequently perceived that patients do not wish to have full disclosure of bad news; however, many patients with terminal cancer want to know all the information pertaining to their diagnosis and prognosis (Tse, Chong, & Fok, 2003). China has instituted a law related to a patient's right to be informed that addresses providers withholding illness information. Prior to the law's implementation, providers could communicate information about the patient's illness to family members, and the relatives would decide what information to tell or to withhold from the patient (Wuensch et al., 2013). Korean Americans and Mexican Americans may not want to be given bad news about their family member with cancer, regardless of the outcome on the patient's illness or prognosis, for fear that he or she may either choose to "give up" or choose not to proceed with treatment as a result of the bad news (Tuckett, 2004). In some cultures, cancer is taboo and families may be stigmatized when a member of the family is being diagnosed with or being treated for a malignancy (Abazari, Taleghani, Hematti, & Ehsani, 2016). For many Iranian patients, it is important to reduce the stigma of a cancer diagnosis by encouraging a positive outlook on treatment and by reminding the patient that many individuals have cancer or a comorbid condition from cancer (Abbaszadeh et al., 2014). Offering diagnostic or prognostic information to the patient is considered a duty in Iran, and nurses typically support the patient and his or her family throughout the cancer trajectory (Abbaszadeh et al., 2014).

In addition, a study by Dias, Chabner, Lynch, and Penson (2003) indicated that patients desire clinicians to be skillfully trained and well-equipped to provide culturally sensitive care. Because not every patient reacts the same way to culturally specific generalizations (Rao et al., 2016), nurses or clinicians should ask each individual his or her preferences on full disclosure of information prior to breaking bad news.

Barriers to Effective Communication

Nurses may be unaware that they lack adequate knowledge and expertise when breaking, or recommunicating, bad news to patients and families (Adebayo, Abayomi, Johnson, Oloyede, & Oyelekan, 2013). Confidence and experience are critical factors in communicating serious news. Feeling prepared, educated, and well-rehearsed can enhance confidence when delivering bad news (Mishelmovich et al., 2016). However, for some individuals, no correlation exists between the amount of training and comfort level with breaking bad news (Lifchez & Redett, 2014). The notion of losing control of the conversation when breaking bad news can debilitate confidence and create awkwardness at a time when the patient relationship must be positive (Friedrichsen & Milberg, 2006).

The physical space where bad news is delivered is considered the most important aspect of breaking bad news (Baile et al., 2000; Kaplan, 2010). From a patient perspective, most clinical settings are not conducive to breaking bad news effectively. A lack of privacy in an emergency department setting or deficiency of time in a busy, overbooked outpatient office can hinder communication, resulting in lasting negative effects (VandeKieft, 2001). Choosing an appropriate, quiet, and private area that is free of interruptions conveys respect and maintains a patient's dignity during a difficult time (Fujimori et al., 2005; Kaplan, 2010).

Studies reveal inconsistencies in how nurses and other clinicians believe they communicate bad news and how patients or family members receiving the information perceive the interaction (Toutin-Dias, Daglius-Dias, & Scalabrini-Neto, 2016). A study by Toutin-Dias et al. (2016) indicated that clinicians tend to perceive that the breaking bad news encounter was worse than what the patient and family perceived. Nurses are often critical of their communication techniques and fail to recognize various cues that indicate that the interaction had some degree of positivity. Being sensitive to verbal, physical, and emotional reactions can help guide the degree of caring and support offered during the discussion (Ptacek & Ellison, 2000).

Breaking bad news can be considered an unpleasant task, resulting in hesitancy to fully disclose a terminal diagnosis. A desire to protect the patient from the truth and the extent of his or her illness is another reason full disclosure is not offered to the patient (Al-Mohaimed & Sharaf, 2013; VandeKieft, 2001). To avoid difficult conversations, illness information is often discussed

with family members first before any communication is shared with the patient.

Consequences of Poor Communication

Bad news is often delivered in oncology settings. Nurses can experience a high rate of burnout and compassion fatigue from breaking bad news, which may have distressing effects on professional performance and general health. Thorough preparation for intense, full-disclosure discussions may prevent negative outcomes on job performance and efficiency (Brown et al., 2009). Symptoms of stress, such as increased heart rate and perspiration, can occur while breaking bad news, and the stress response can be sustained well past the conclusion of the encounter (Shaw, Brown, Heinrich, & Dunn, 2013).

Consequences of improper delivery can result in the loss of a patient's trust (Charlton, Dearing, Berry, & Johnson, 2008). A patient may fail to hear important information because he or she is distressed during the interaction. In addition, not disclosing the entire truth can inadvertently create a false sense of hope for a cure and perceptions of a longer life expectancy. In an extreme case, not delivering bad news effectively was directly linked to a patient's suicide (Dias et al., 2003).

Educational Resources

Education and training on breaking bad news and the follow-up support required can enhance communication skills and cultivate the ability to be effective when having a serious dialogue (Reed et al., 2015). Simulation (Tobler, Grant, & Marczynski, 2014) and standardized patient experiences (Tobler et al., 2014) provide environments to refine life-changing, delicate, and emotional discussions. Communication curriculum that includes models for breaking bad news is central to providing care to patients and families (Merckaert et al., 2013). The Breaking Bad News Foundation (2016) is focused on training compassionate communication when delivering traumatic diagnostic and prognostic information.

The Breaking Bad News Foundation created the Breaking Bad News™ Program, which was designed by a neonatologist who recognized the need to train physicians on how to deliver bad or tragic news (Breaking Bad News Foundation, 2016). The model consists of three training components:

- Learners participate in improvisational role-playing sessions with professional actors.
- Participants remotely observe role-playing sessions by certified Breaking Bad News instructors. Simulated interactions are video recorded and viewed by instructors.
- Participants are provided with an opportunity to review the recorded role-playing sessions with instructors, allowing for self-review and reflection with comments and suggestions from instructors.

Although it was originally developed for medical residents to improve communication skills, this model can be adapted and

used for a variety of disciplines. Effective and compassionate communication between clinicians and patients is associated with improved compliance with medications and treatments, patient coping, and decision making (Breaking Bad News Foundation, 2016). The Breaking Bad News Foundation website also provides educational videos and resources (www.bbnfoundation.org/what-we-do/programs.html). The content is aimed at the provider or healthcare professional breaking the bad news; however, nurses can apply this knowledge to support patients and family members following breaking bad news.

Another resource that discusses breaking bad news techniques is a website by Irene Tuffrey-Wijne, PhD, a nurse scholar at the University of London (www.breakingbadnews.org). Tuffrey-Wijne has developed the website for all healthcare providers aimed at breaking bad news to people with disabilities. The website provides a step-by-step process for breaking bad news that is similar to the SPIKES and PEWTER evidence-based models of communication. Tuffrey-Wijne's website also provides hypothetical scenarios that can be used in clinical training.

In addition, nurses who want to offer training to their colleagues for supporting patients after they have received bad news can develop short role-play scenarios. Each participant can play the nurse who is supporting a patient following distressing news. Experiential learning can occur based on the SPIKES and PEWTER models.

SPIKES and PEWTER Models of Communication

Several evidence-based models have been developed and adapted for nursing clinical practice when delivering bad news. The most common models that are widely represented in the literature are the SPIKES (Setting, Perception, Invitation/information, Knowledge, Empathy, and Summarize/strategize) model (Baile et al., 2000) and the PEWTER (Prepare, Evaluate, Warning, Telling, Emotional response, Regrouping preparation) model (Keefe-Cooperman & Brady-Amoon, 2013).

SPIKES Model

The SPIKES model provides a mnemonic for defining a structured plan for delivering bad news to patients and their families (Baile et al., 2000; Kaplan, 2010). The SPIKES model was initially designed for oncology care, specifically for difficult discussions such as when cancer recurs or when palliative or hospice care is indicated. The *setting* involves selecting a quiet and private area to demonstrate respect and empathy for the patient and family. *Perception* means that the nurse should determine the patient's understanding and perceptions about the situation before fully presenting the information and associated plan of care. *Invitation* or *information* indicates that the nurse should determine how much and what kind of information would be helpful for the patient and family based on their needs and reactions. This step provides a framework for information presented later. *Knowledge*

considers the point in which the bad news is shared. Information about the extent of disease and plan of care is provided directly and honestly in small segments, avoiding use of medical jargon. The nurse should ask the patient and family members what they understand and offer additional clarification. *Empathy* is acknowledging emotions and reactions of the patient and family during the discussion and responding to them in an appropriate manner to demonstrate empathy. To *summarize* or *strategize* requires the nurse to explain the information presented in an understandable language (Baile et al., 2000). Once the news has been summarized, the nurse can discuss the care management plan and treatment options with the patient.

PEWTER Model

The PEWTER model also provides a mnemonic for defining a framework to communicate bad news effectively. The PEWTER model was originally created as a tool for school counselors but has been effectively used in clinical settings when delivering life-changing news to patients (Keefe-Cooperman & Brady-Amoon, 2013; Nardi & Keefe-Cooperman, 2006). The first aspect of the model is to *prepare*, which includes knowing what information will be presented and understanding how to present it in clear, everyday language. Preparation should also include providing an unhurried and uninterrupted meeting with the person receiving the difficult news. *Evaluate* refers to the assessment of what the patient and family members already know or suspect and should include the cognitive and psychological status of the patient, as well as awareness of personal emotions, body posture, and facial expressions. *Warning* refers to giving the patient an indication that serious news will be presented. The warning should allow for a brief pause for the patient to mentally and emotionally prepare before the nurse proceeds with breaking bad news. *Telling* involves the presentation of information in a straightforward and nonapologetic and calm manner. The bad news should be given in small pieces, with no more than three pieces of information given at a time, and nurses should confirm understanding prior to disclosing any additional information. Limiting information allows the nurse to ensure that the information is received and that the patient and family are not overwhelmed. *Emotional response* requires the nurse to assess the patient's reaction to the bad news. If the patient is overwhelmed, it may be necessary to have more than one meeting to discuss the bad news. Finally, *regrouping preparation* involves patient-nurse collaboration to respond to the bad news. This phase is often viewed as the most important because it concerns offerings of hope. In many situations, hope for treatment, hope that the patient's quality of life will be maintained, and hope that the prognosis is not life-limiting can be part of the discussion without being unrealistic (Nardi & Keefe-Cooperman, 2006). However, in some cases, hope may not be evident and, therefore, should not be discussed. Being hopeful involves remaining engaged in iden-

tifying and working toward new, often revised, goals (Bruininks & Malle, 2005).

Applying Breaking Bad News Models to Practice

Adopting a model for breaking bad news can inspire the confidence required for effective discourse. No consensus as to which model is a best practice standard exists; therefore, nurses can incorporate either the SPIKES or PEWTER models to present and support the relay of bad news. The goal is to become comfortable and well versed in the delivery and discussion of bad news. The more comfortable a nurse is with breaking bad news, the more likely it is that a better outcome will ensue (Dias et al., 2003). To be focused, thorough, therapeutic, and effective while breaking bad news requires preparation, a review of current evidence, and a communication model for practice. The earlier clinical case study continues in this section to demonstrate how the breaking bad news evidence-based communication models can be applied to nursing practice.

The following example depicts the oncology nurse's incorporation of the SPIKES model. The nurse smiles as she and the medical oncologist open the door and see the patient sitting in the examination room. As the patient begins to cry, the nurse remembers the SPIKES model for delivering bad news. The setting where the bad news is delivered is private and quiet. The patient is realistic about her diagnosis and knows that her breast cancer can become metastatic at any time. The nurse determines that the patient is in a physical and emotional position to receive the bad news and that she will require a great deal of cancer treatment information. Providing full disclosure about the bone metastasis as soon as possible is appropriate so that the patient can ask questions and gather information. The nurse empathetically determines the patient's level of understanding and summarizes the discussion after the oncologist leaves the room.

Individual situations will determine the order in which each element of the SPIKES model is delivered. Information may need to be repeated or clarified, with further questions addressed at subsequent sessions or during follow-up telephone calls.

The following example depicts the oncology nurse's incorporation of the PEWTER model with the same patient. The nurse can smile as she opens the door and sees the patient sitting in the examination room. As the patient begins to cry, the nurse remembers the PEWTER model for delivering bad news. The nurse has prepared herself by reviewing the clinical data, thinking through the conversation, planning the environment where the conversation can take place, and anticipating the patient's questions. She knows that the patient is realistic about her diagnosis, notices that her posture is open, and sees that her facial expressions are serious. The nurse cares for the patient and wants the healthcare team to provide full disclosure of the patient's prognostic situation. The oncologist begins the discussion by stating that she has some serious news to share and tells the patient that the cancer

has spread to her bones, that it is treatable but not curable, and that she will require radiation. The nurse evaluates the patient's facial expressions and emotional response and determines that the information is being received thoroughly. The nurse restates the care management plan after the oncologist has left the room and provides more information as needed.

The PEWTER model suggests that preparation is the first step in breaking bad news. The PEWTER model is similar to the nursing process in preparation and assessment before the intervention (the bad news) is delivered, then the patient receives support and clarification from the nurse. When breaking bad news, a nurse should provide small amounts of new data to allow the patient time to process all of the information appropriately. Determining the emotional response is also important to ensure the patient is comprehending the new data.

Combining the SPIKES and PEWTER Models

Although effective independently, combining the SPIKES and PEWTER models is also a possible communication strategy for practicing oncology nurses. For example, the nurse can prepare and think through the conversation prior to the interaction; anticipate the patient's reactions and provide meaningful support; determine the amount of information already known and how much information is desired; and understand the diagnosis, what has been communicated about the diagnosis, and the intended care management strategies. Because other healthcare team members may have initially discussed the bad news with the patient, it is important to ensure consistency when delivering additional information. Nurses should evaluate their own emotional response and maintain composure to be caring yet objective and supportive. Similarly, nurses must demonstrate empathy, allow for the patient and family's own emotional responses, and give them time and privacy for processing the news. Empathetic behaviors can include active listening and trying to understand feelings from the patient perspective. More information on empathy can be found from the University of California Berkeley–Greater Good Science Center (Eva, 2017). Finally, nurses can set goals and establish a strategy for care management and emotional support. Providing support can enhance coping, and nurses should also consider additional ways to reduce the emotional impact of bad news. Compassion, sensitivity, and kindness are also essential when breaking bad news and can help make a difficult time better for many patients and families (Radziewicz & Baile, 2001).

Conclusion

Evidence-based education and training will enhance effective communication when breaking bad news in clinical practice. Ineffective communication of bad news can have lasting negative effects on providers, patients, family members, and nurses. Although no single best practice model is recommended over another, evidence-based models of communication for breaking bad

IMPLICATIONS FOR PRACTICE

- Prepare for difficult conversations by fully understanding the extent of the patient's cancer diagnosis and choosing a quiet, private setting for the discussion.
- Set discussion goals prior to meeting with the patient and family members to ensure information is relayed appropriately.
- Adopt an evidence-based communication model to guide the delivery of bad news associated with a cancer diagnosis, disease progression, and treatment.

news, such as the SPIKES and PEWTER models, can help guide nurses in practice and provide communication strategies that can be used based on the specific patient or setting. Best practice should reflect the elements of the SPIKES and PEWTER models to guide difficult discourse.

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QUESTIONS FOR DISCUSSION

USE THIS ARTICLE FOR JOURNAL CLUB



Journal club programs can help to increase your ability to evaluate the literature and translate those research findings to clinical practice, education, administration, and research. Use the following questions to start the discussion at your next journal club meeting.

- How do you prepare yourself to support a patient receiving bad news?
- How do you address cultural considerations when breaking bad news to patients or their family members?
- How do you choose the setting where you deliver bad news to patients?
- How would you apply the SPIKES model in your practice?
- How would you apply the PEWTER model in your practice?

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