Preparing Prelicensure and Graduate Nursing Students to Systematically Communicate Bad News to Patients and Families

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ABSTRACT
Communicating bad news, otherwise known as difficult conversations, is a complex communication skill that requires didactic learning and practical application. Students learn that what may be interpreted as bad news is determined by the recipient and not by the person who is delivering the news. Learning a systematic approach, such as the SPIKES (Setting, Perception, Invitation, Knowledge, Empathy, Strategy/Summary) mnemonic, prepares prelicensure and graduate nursing students for difficult conversations with patients and families in the clinical setting. Role-playing commonly includes clinical scenarios, and using video recording and playback of the encounters in such scenarios is one method of learning the systematic approach to communicating bad news. Follow-up practice after application in the clinical setting and feedback from faculty and mentors are essential for nursing students to achieve competence in this complex set of communication skills. [J Nurs Educ. 2013;52(1):xxx-xxx.]

Partnering with patients and families to manage patients’ health often involves difficult conversations regarding health care decisions. Bad news delivered poorly can become a negative experience that lingers in the minds of patients and families. Many times, the difficult conversation is not a one-time occurrence, but rather can be the beginning of a relationship that may affect the future coping abilities of patients and families. Much of the literature regarding the process of delivering bad news describes physician training challenges (Bonnaud-Antignac, Campion, Pottier, & Supiot, 2010; Gough, Frydenberg, Donath, & Marks, 2009; Harrison & Walling, 2010). However, nurses often also have these conversations. Dedicated preparation in communicating bad news, also referred to as difficult conversations, for both prelicensure and graduate nursing students better prepares them for uncomfortable conversations in the clinical setting.

Teaching the skill of delivering bad news requires a multi-pronged approach to help students achieve competence in this complex set of communication skills. It requires didactic learning, including scenarios involving practical application and follow-up practice after application of such skills in the clinical setting.

Didactic Learning
Student didactic learning begins with an overview of the type of information patients and their families commonly interpret as bad news. Educational programs dedicated to teaching the skill of delivering bad news often have a specific focus on intensive care, emergency care, or oncology practice (Harrison & Walling, 2010). Learning the complex communication technique of delivering bad news is a skill that can also be generalized to many situations outside of critical illness and end-of-life discussions. When asked to provide examples of bad news, students initially indicate a new diagnosis or a dismal prognosis. However, students can learn to recognize that what qualifies as bad news is determined by the recipient; thus, what may seem routine or trivial to a student or health care provider may be viewed by a patient or family as bad news. For example, telling a patient that his or her surgery needs to be rescheduled or that a planned family care conference has been cancelled can be distressful to the patient and family who have been waiting for the event and who may have taken time off from work or made travel arrangements to be at the hospital. A frequent source of bad news in the pediatric setting is the need to evaluate a neonate for the source...
of a fever. Although lumbar punctures, urinary catheterizations, and venous blood draws are common occurrences for nursing staff, these procedures are frightening for new parents. Increasing student awareness that patients and families interpret information differently from those who are communicating the information is invaluable and can significantly impact a family’s health care experience and enhance partnerships.

When students understand the concept of bad news, they next learn that disclosing bad news is aided by learning a systematic approach. One six-step approach uses the mnemonic SPIKES (Setting, Perception, Invitation, Knowledge, Empathy, Strategy/Summary [Buckman, 2005]).

**Setting**

The first step is to determine the focus of the conversation and prepare the setting. The most important part of this step is to identify the specific message to be communicated. For example, to inform a patient that he or she has cancer and then provide every detail about the cancer is too much information for an initial conversation. The focus of the first conversation should be the diagnosis only. The patient and family will need time to process the new information. Preparing the setting for this type of conversation involves arranging for a private location; determining who should be present at the meeting, including an interpreter if necessary; avoiding interruptions and addressing time constraints; confirming the facts; and thinking through the plan for disclosure (Baile et al., 2000). Anticipating difficult questions that the patient or family might ask provides the nurse with time to thoughtfully reflect on his or her responses before the meeting.

**Perception**

The second step is to assess how the patient and family perceive the medical situation and to determine how much they already know (Buckman, 2005). A lead in question to this initial part of the conversation may be, “What have you been told so far about...?” In times of perceived crisis, it is difficult for patients and families to recall everything they are told. This step provides the nurse with an opportunity to evaluate the patient’s and family’s understanding and to reinforce previous knowledge.

**Invitation**

Next, the nurse invites the patient and family to express how much detail they would like regarding the issue (Buckman, 2005). A simple question such as “How much information would you like for me to give you about your diagnosis?” will help to guide the next step of the conversation. This step is especially important for families of pediatric patients. Often, it is decided to share knowledge with the family first and then design a plan to share with the child at a later time.

**Knowledge**

The fourth step is to communicate the information in straightforward terms that are aligned with those used by the patient and family (Buckman, 2005). It is helpful to begin this step with a warning phrase that bad news is coming (Buckman, 2005). A phrase such as “I feel badly that I have to tell you this,” followed by a pause, prepares the patient and family that what is said next is not going to be perceived as good news. It draws the patient’s and family’s attention to the next sentence that is communicated, again in straightforward terms, followed by another pause. An example of this is “Your baby’s fever may be a sign of a serious infection, and we need to do some tests.” The pause allows the nurse to evaluate the family’s understanding. In this example, the parent or caregiver might then ask, “What kind of tests?” Information is shared in short sentences, followed by pauses. Generally, nurses want to get through this step quickly and deliver all of the information at once; therefore, this step requires extensive practice and requires nurses to become comfortable with pausing.

**Empathy**

Responding to the patient’s and family’s emotions by acknowledging and identifying their feelings and allowing time for a response is part of the fifth step (Baile et al., 2000). Nurses learn to be comfortable with silence and to not fill the silence with more details while the patient and family process the information already disclosed.

**Strategy/Summary**

The last step is to discuss the next plan and often involves shared decision making with the patient and family (Buckman, 2005). Basic plans should be determined prior to the meeting. For example, if the bad news is that surgery is cancelled, then information regarding when it can be rescheduled and whether examinations and blood work, even blood donation, need to be repeated prior to the next surgical date is necessary to have available. If the patient is a child, the shared decisions might be when to inform the child and how this can be undertaken. For example, should child life experts assist with disclosing the diagnosis to the child?

**Practical Application**

The six steps described can be provided to students on a pocket card so it can be kept with them in the clinical setting. Following review of the SPIKES approach, faculty can demonstrate good and poor examples of communicating bad news. Students can follow along, using a checklist with components of the six-step approach, to evaluate the examples provided by faculty. Following each demonstration, faculty members can lead a debriefing to identify areas of strength and areas for improvement.

The systematic approach to having a difficult conversation is then practiced in small groups through role-playing of selected case study exercises. These exercises are brief vignettes developed by faculty, describing common clinical scenarios. One student may be identified as a family member, another as the patient, and another as the nurse communicating the bad news. The use of role-playing, followed by directed reflection or debriefing, improves students’ self-awareness and confidence in handling difficult conversations.

Numerous strategies to enhance learning during role-play are based on available resources. Multiple small groups can work through the same exercises in one large room or the groups can be separated into individual spaces, if available.
An alternative strategy is to use a simulation laboratory with video recording capabilities. One group can be recorded while the other groups observe. The use of professional actors, rather than fellow students, in roles of patients and families is another option (Gough et al., 2009). The actors, if they have teaching qualifications, can become a valuable part of the individualized feedback process (Gough et al., 2009). Although trainees benefit from more real-life scenarios, simulation laboratories and professional actors present financial and logistical problems (Gough et al., 2009). Regardless of the room arrangement and availability of a simulation laboratory or professional actors, a video recording of one small group for each scenario should be performed using a small, handheld camera. Capturing role-play exercises on video can be a powerful learning tool because students are often unaware of their mannerisms or phrasing until they see and hear themselves on the video. For the students’ role-play, the same process as that of the faculty demonstrations of following along with the checklist and debriefing is followed. Directed reflection or debriefing involves analyzing scenarios so that lessons learned can be applied to future practice by the entire group.

**Follow-Up Practice After Application in the Clinical Setting**

Students often describe communicating bad news to be more challenging in the clinical setting than anticipated during practice sessions. A particular challenge for students is active listening and the use of pauses to allow time for the patient and family to process the communicated information. Gough et al. (2009) found that trainees struggled with planning ahead and slowing down the conversation. Another challenge is the impulse to offer false hope in a dire situation or to lessen the prognosis or condition of the patient (Mack & Smith, 2012). Evidence suggests that providing honest prognostic information may allow patients and their caregivers to better cope and to allow for a greater level of empowerment regarding medical care decisions (Mack & Smith, 2012). Although it is important to not destroy hope, most patients and families desire honest and detailed information (Buckman, 2005; Mack & Smith, 2012).

During the initial role-playing session to practice the systematic approach, the case scenarios should be straightforward. Reinforcement of learning should be evaluated in follow-up practice sessions scheduled later in the students’ program of study. During the second session, students can be evaluated with more complex case scenarios. The communication of bad news can also be integrated into larger exercises of clinical decision making, rather than separated into an isolated skill. Faculty can assess student progress by reviewing case study exercise videos from session one and comparing them with videos from session two, using an assessment grid derived from the six-step approach that lists components of each step. Student confidence can be evaluated with a self-assessment questionnaire before and after each session, and results can be statistically correlated.

Bonnaud-Antignac et al. (2010) conducted a study on the success of a three-part training course for residents on communicating bad news. The first session was lecture and discussion of the six-point stepwise approach (Bonnaud-Antignac et al., 2010). The second session occurred 1 to 8 weeks later, when each student was video recorded during a simulated patient interview in which the student communicated bad news to a professional actor playing the patient (Bonnaud-Antignac et al., 2010). A psychologist analyzed the communication technique, and student feedback was provided (Bonnaud-Antignac et al., 2010). Another 1 to 2 weeks later, a senior physician provided individual feedback, while reviewing the video with the student (Bonnaud-Antignac et al., 2010). One half of the students studied reported that their communication skills had improved after sessions one and two, but 75% of the students felt more confident with their communication approach after receiving feedback in the third session by a senior physician (Bonnaud-Antignac et al., 2010). These results reinforce the importance of individualized feedback by mentors on communication techniques and learning over time, rather than during one planned activity.

**Discussion**

Mentorship by experienced colleagues is a key component to enhancing communication skills with patients. Although simulation case study exercises can better prepare students for complex interactions, peer-support groups and debriefing formally or informally with colleagues following real-life encounters is crucial for ongoing emotional support and future growth; thus this skill should also be taught as continuing education in the clinical setting.

Integrating cultural and spiritual beliefs into discussion and case scenarios is an important element of skill development. Understanding a patient’s cultural norm related to health care is essential prior to difficult discussions. Culture and spirituality cannot be inferred, and health care professionals should approach diverse patients and families by demonstrating an interest in their cultural and spiritual beliefs. Informing the patient that people view illness and death in many different ways and allowing them to share their beliefs permits the patient and family to be the cultural educators (Old, 2011). Students must take care to avoid stereotyping based on culture or spiritual affiliation (Old, 2011). In addition, when a language barrier is present, nurses must arrange for an interpreter. Native speakers of the language can interpret words into more acceptable cultural terms (Old, 2011).

The systematic approach of communicating bad news can also be modified and applied to difficult conversations regarding disruptive behavior among colleagues. Incivility in the workplace is common, and responding to a bully is difficult, but required, to build a culture of respect (Longo, 2010). Using this six-step systematic approach to conversations among colleagues empowers nurses to address incivility. Unfortunately, such situations do occur in the clinical setting and require tactful practice and thoughtful reflection.

Incorporating formal learning in communicating bad news into nursing education and in continuing education will better prepare nurses to develop the complex communication skills essential to optimal patient- and family-centered care. A systematic, individualized, and well-prepared approach to disclosing bad news can leave a positive impact on a patient or family during a challenging time of their lives.
References


