

A CONTINUING EDUCATION ACTIVITY



Experiences of Nurse Practitioners in Communicating Bad News to Cancer Patients

A continuing education article for nurse practitioners, clinical nurse specialists, advanced degree nurses, and oncology and hematology nurses.

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Activity Rationale and Purpose

Communication is key to success throughout the trajectory of illness, whether among the collaborative practice team, with primary/referring providers, or with patients. Advanced practitioners (APs) are often called upon to provide patient education, test results, and/or to discuss prognosis, which can include bad news. How they communicate information to their patients and/or caregivers helps to establish trust and can also help the patient/caregivers cope through their journey with cancer. Good communication is a skill that can be taught and learned. This article uses the SPIKES protocol to illustrate how good communication can be learned, and how it ultimately impacts the practitioner's caregiving experience.

Intended Audience

The activity's target audience will consist of nurse practitioners, clinical nurse specialists, advanced degree nurses, and oncology and hematology nurses.

Learning Objectives

After completing this educational activity, participants should be able to:

1. Describe the challenges and barriers to effectively communicating bad news to cancer patients.
2. Explain the six-point SPIKES protocol and its clinical application.

Continuing Education

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Experiences of Nurse Practitioners in Communicating Bad News to Cancer Patients

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Abstract

How oncology practitioners communicate with patients has a strong impact on quality health care. Good communication facilitates positive experiences for both practitioners and patients alike, yet many practitioners report they are inadequately prepared for delivering bad news to cancer patients and often have negative experiences due to poor communication. Using a qualitative exploratory descriptive design this study sought to understand the experiences of nurse practitioners (NPs) when communicating bad news to cancer patients. Methodology consisted of two steps. First, five Florida-licensed NPs with at least 2 years of oncology experience were educated on the use of the SPIKES protocol and utilized it in clinical practice for 30 days. Second, semistructured individual interviews were conducted to record their perceptions of using the SPIKES protocol. Thematic analysis results support the concept that “the experiences of the nurse practitioner when delivering bad news to cancer patients are shaped by their own communication skills.” Educating oncology NPs in using the SPIKES protocol when delivering bad news has the potential to positively impact the experiences of both NPs and patients.

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In 1995, *Breaking Bad News Consensus Guidelines* were published (Girgis & Sanson-Fisher, 1995). They called for improved medical provider communication with patients outlining there was a lack of research in the specific steps in delivering bad news and recommending re-

search be undertaken both on patient and provider perceptions in the delivery of such news.

The SPIKES protocol is one such step-wise framework for delivering bad news that can support discussions, improve communication, enhance practitioner confidence, support patient-centered care, and

facilitate a shared decision-making model in patient care. This tool is an acronym for the steps in which to deliver bad news (see Table 1). Since the 1990s, research has continued to expand on communication tool training and implementation for medical providers and students in training to be health-care providers.

REVIEW OF THE LITERATURE

Research has shown that when poor communication is used to deliver bad news, cancer patients often suffer significant emotional and psychological trauma and are at risk of receiving less-than-

optimal quality of care (Horne, Seymour, & Payne, 2011; Thorne et al., 2013). Research demonstrates that communication skills training and using a tool to assist in the development of a therapeutic relationship positively impact patients and their relatives (Epstein & Street, 2007; Fujimori et al., 2014; Merckaert et al., 2013; Morgans & Schapira, 2015).

More recently, research in this important area has expanded to evaluate the way in which formal communication skills training impacts not only patients, but also the “deliverer” of the bad news, such as the medical student (Kiluk, Dessureault, & Quinn, 2012; Skye, Wagenschutz, Steiger, & Kum-

Table 1. SPIKES: A Six-Step Protocol for Delivering Bad News to Patients

Steps	Suggestions
<p>Step 1: S—Setting up The setting should provide for privacy and comfort to encourage communication. Body language should include facing the patient, eliminating distractions, and making eye contact, and it should be appropriate culturally for each patient.</p>	<ul style="list-style-type: none"> • The meeting should be private • Invite significant others to be a part of the meeting • Sit down at eye level with the patient • Make eye contact and a face-to-face connection with the patient • Avoid interruptions and manage time constraints
<p>Step 2: P—Assessing patient's perception Listen to the way the patient describes the situation to identify the level of comprehension and degree of denial. Give the bad news in a way the patient will understand.</p>	<ul style="list-style-type: none"> • Gain knowledge of what the individual already knows • Use open-ended questions: What have you been told? What is your understanding?
<p>Step 3: I—Obtaining the patient's invitation Unless prepared to receive bad news, the patient may not understand serious and/or complicated information.</p>	<ul style="list-style-type: none"> • Ask if the patient is willing to accept information by asking, how would you like me to give the information about the test results? • Provide information disclosure
<p>Step 4: K—Giving knowledge and information to the patient Once you understand the patient's level of comprehension, you can begin the educational process by giving important information a little at a time making sure it is understood. When the diagnosis is negative, avoid such statements as “there is nothing more we can do for you.”</p>	<ul style="list-style-type: none"> • At the individual's level of understanding and vocabulary, warn the patient that bad news is coming: Unfortunately, I've got some bad news to tell you I'm sorry to tell you that... • Use nontechnical words • Avoid excessive bluntness
<p>Step 5: E—Addressing the patient's emotions with empathic responses By first observing for the patient's emotional reaction, use open-ended questions. Next, identify the reason for the emotion and allow the patient time to express it by showing concern.</p>	<ul style="list-style-type: none"> • Recognize and respect the reactions and feelings of the patient and family • Patients' emotional reactions may vary from silence to disbelief, crying, denial, or anger • Offer support to the patient by making an empathic response • Let the patient know you care
<p>Step 6: S—Strategy and summary Before the end of the meeting, be sure to summarize the important points discussed and set the time and place for the next meeting. Patients who have a clear plan for the future are less likely to feel anxious and uncertain.</p>	<ul style="list-style-type: none"> • Ask if the patient has any other questions • Present treatment options (when available) to the patient • Allow the patient to be a part of the decision-making process • Make sure the patient has no misunderstanding of the discussion

Note. Information from Baile et al. (2000).

agai, 2014); nursing student (Little & Bolick, 2014); nurse (Baer & Weinstein, 2013; Banerjee et al., 2016; Bylund et al., 2011); clinical nurse specialist (Mishelmovich, Arber, & Odelius, 2016); physician (Bylund et al., 2011; Fujimori et al., 2014; Grainger, Hegarty, Schofield, White, & Jefford, 2010; Mercckaert et al., 2013); or other related nonphysician health-care providers such as the social worker, nurse practitioner (NP), or physician assistant (PA; Bylund et al., 2011; Parker et al., 2010).

However, although research on the “deliverer” is beginning to be amassed, it appears that few studies have examined nurse practitioners as a separate entity (Rosenzweig, 2012), and for the few that included NPs in research as subjects, they were often grouped with nurses (Bylund et al., 2011). This lack of research with advanced practitioners demonstrates the need for empirical research with NPs and PAs, as these health-care providers are on the front lines of delivering bad news and need expert communication skills.

Historically, physicians may have uncertainty in deciding the best way in which to share difficult news with patients (Curtis et al., 2002; Park et al., 2010). Like their physician colleagues, many NPs report they are inadequately prepared or trained for this task and often have negative experiences (Rosenzweig, 2012; Warnock, Tod, Foster, & Soreny, 2010). Baile et al. (1997, 1999) found that less than 10% of providers were trained to deliver bad news in a manner that supported the needs of cancer patients, leading to their experiencing significant suffering as recipients of poor communication (National Cancer Institute [NCI], 2015; Thorne et al., 2013).

To reiterate, research with medical students and physicians demonstrates that the skill of communicating bad news can be taught through communication skills training. Therefore, formal communication skills training is beginning to be standardized in medical provider curricula but has not traditionally been a routine part of NP education. However, many NPs currently in practice have often learned by observing physicians, who may also have limited communication skills training themselves before this was standard in their medical education (Rosenzweig, Clifton, & Arnold, 2007).

Literature review reveals that implementing education may not be enough to enhance the feel-

ing of confidence with the skill and that continued practice in the clinical setting is warranted, as it can be more challenging in the clinical setting than in practice (Barth & Lannen, 2011; Little & Bolick, 2014). Further research with additional communication training for NPs in clinical practice is needed.

To meet the communication needs of patients, NPs must learn to communicate in a manner that delivers bad news in a supportive fashion while at the same time allowing patients to be a vital part of their cancer treatment plan (Baile et al., 2000), a concept supported in the theory put forth by the National Cancer Institute’s Conceptual Framework for patient-centered communication in cancer care, as adapted by the authors (Figure; Epstein & Street, 2007; Perocchia et al., 2011). Delivery of bad news using frameworks such as the SPIKES protocol can help facilitate these vital elements in this theory (Kaplan, 2010; Kiluk et al., 2012; Little & Bolick, 2014; Morgans & Schapira, 2015).

Although the position paper by the NCI (2015) recommends the SPIKES protocol as a communication skills training tool for providers when delivering bad news to oncology patients, little research has specifically examined NPs’ communication with oncology patients. Since research supports that communication training improves the confidence of participants (Fujimori et al., 2014; Grainger et al., 2010; Mishelmovich, Arber, & Odelius, 2016; Skye et al., 2014) and the self-efficacy of health-care professionals from several disciplines (Bylund et al., 2011; Kissane et al., 2012), further research is needed specifically examining NPs and their experience with use of the SPIKES framework. To the best of the authors’ knowledge, research specifically with NPs in clinical practice has not yet been conducted in how the implementation of the SPIKES framework impacts them when delivering bad news.

NCI’s Framework for Patient-Centered Communication in Cancer Care

Improvement in the delivery of patient-centered communication has been identified as a priority in the NCI’s plan for research to reduce the pain and suffering of cancer patients. To deal with these issues, the NCI developed a conceptual framework built on six core functions to support

both the provider and patient as a communication template for patient-centered cancer care (Epstein & Street, 2007; Perocchia et al., 2011). These functions include the following: fostering healing relationships, exchanging information, responding to emotions, managing uncertainty, making decisions, and enabling patient self-management. In the context of this study, these six elements served as a framework to support facilitation of individual interviews with participants and utilization of a communications skills' training protocol for NPs when dealing with oncology patients.

METHODS

Design and Procedures

After institutional review board approval was obtained, a flier announcing the research study was distributed to two professional groups: the Central Florida Chapter of the Oncology Nursing Society (CFONS) and the Greater Orlando Hematology Oncology Physician Extenders (GO HOPE).

Five NPs volunteered to participate in this two-part study utilizing a qualitative exploratory descriptive. In step one, a meeting with each NP was conducted to obtain informed consent and provide education on the use of the SPIKES Six-Step Protocol for Delivering Bad News to Patients (Table 1). Participants were asked to employ the tool in their clinical practice for 30 calendar days (1 month).

Thirty days later in step two, individual one-on-one interviews were conducted and recorded.

Interview questions consisted of five scripted, open-ended, qualitative discussion questions, which were developed based on the NCI's Conceptual Framework for patient-centered communication in cancer care, and are listed here (Figure; Epstein & Street, 2007; Perocchia et al., 2010).

Nurse practitioners were asked to share their perceptions, experiences, and insights on the changes or differences the protocol made in their relationships with patients. Additionally, participants were questioned about the tool's usefulness in helping patients in problem-solving and decision-making. To maintain patient privacy, the researcher discouraged all discussion regarding specific patients, and no data were collected on any specific patient.

Sample

Participants were female, with an average age of 33.8 years, and had 2 to 10 years of professional experience. All worked in private practice, with three reporting associated acute care duties. Two participants had Doctorate of Nursing Practice degrees (DNP) and three had Masters of Science in Nursing degrees (MSN). Three participants were certified as "Advanced Oncology Certified Nurse Practitioners," and two were certified as "Adult Nurse Practitioners."

Data Analysis

Interviews were transcribed by the investigator, and a six-step process conducting thematic

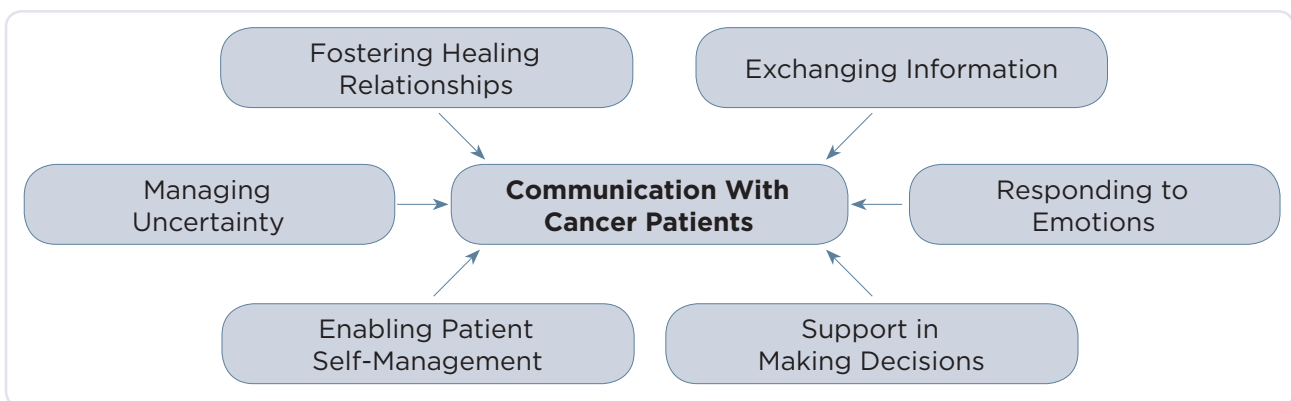


Figure. Visual representation of the National Cancer Institute's Conceptual Framework for patient-centered communication in cancer care and caring through communication with cancer patients. Adapted from Epstein & Street (2007); Perocchia et al. (2010).

network analysis was utilized to extract common themes from individual interviews; they were used to evaluate and understand each study objective (See Table 2; Terry, 2012). Validity and reliability were achieved by employing triangulation, saturation, concept checking, and bracketing.

Results and Discussion of Themes

As part of the individual interviews, participants were asked five questions regarding their use of the SPIKES protocol when delivering bad news to cancer patients in practice.

Question 1: *Did the SPIKES protocol foster a healing, compassionate relationship between you and your patient when bad news was communicated?*

Themes that arose from participants' responses supported the concept that the SPIKES protocol helped to establish a relationship between patient and NP by providing a supportive relationship. Subthemes that arose included (1) being deliberate; (2) developing a sense of compassion; (3) becoming more personable; (4) limiting misunderstanding; and (5) giving it time.

Question 2: *Did the SPIKES protocol help you to respond to the emotions exhibited by your patients in a sensitive manner, allowing for their cultural and spiritual beliefs?*

Themes that arose from participants' responses supported the concept that the SPIKES proto-

col builds understanding that promotes emotional support. Participant subthemes related to this question included promoting emotional support through (1) understanding; (2) watching emotions; (3) recognizing and respecting; and (4) creating space consideration.

Question 3: *Did the SPIKES protocol help to support your patients in problem-solving and encourage them to participate in decision-making related to their care?*

Themes that arose from participants' responses supported the concept that the SPIKES protocol supports patient understanding, leading to patient problem-solving and decision-making. Subthemes related to this question included (1) patient problem-solving; (2) patient decision-making; and (3) patient understanding.

Question 4: *What are the facilitators provided by the SPIKES protocol when trying to create a healing environment for your patients that respects their human dignity when giving them bad news?*

Themes that arose from participants' responses supported the concept that the SPIKES protocol promotes a positive environment when delivering bad news. Subthemes that arose included (1) promoting a quiet environment; (2) creating a private environment; and (3) intentionally arranging the best setting for difficult conversations.

An additional theme that arose from participants' responses to this question supported the concept that the SPIKES protocol supports a respectful environment that provides human dignity, and subthemes included (1) not rushing; (2) respect; and (3) intentionally supportive body language.

Question 5: *What elements of the SPIKES protocol helped you to promote patients' self-management while meeting their basic physical, emotional, and spiritual needs?*

Themes that arose from participants' responses supported the concept that the SPIKES protocol allows for information giving that supports self-management and decision-making. Subthemes included (1) understanding; (2) self-management; (3) decision-making; (4) partnering; and (5) giving information.

A second concept that emerged from participants' responses to this question was the concept that the SPIKES protocol promotes holistic pa-

Table 2. Six-Step Qualitative Analysis of Study Data

1. Data were coded utilizing a numerical system to process the text into small segments.
2. Themes were identified by examining each text segment to expose underlying patterns.
3. Fundamental themes were arranged into like groups. Organizational themes were created based on likeness and thematic content.
4. Organizational themes were grouped together, which allowed overall themes to surface, facilitating the conception of the data.
5. Global thematic findings were formed.
6. Deductions were made based on the findings and compiled to build on the theory recognized in the National Cancer Institute's Conceptual Framework for patient-centered communication in cancer care (Epstein & Street, 2007; Perocchia et al., 2010).

Note. Information from Terry (2012).

tient care. Subthemes that arose from participants' responses included (1) physical; (2) emotional; (3) spiritual; and (4) cultural.

Finally, results from this study revealed there were common global themes among participants when utilizing the SPIKES protocol. Utilizing Terry's (2012) thematic analysis process, in four of the five interview questions, all participants shared common themes. They included seven global themes obtained from the data. These themes include that the SPIKES protocol:

- Helps to establish a relationship between patients and NPs
- Builds understanding that promotes emotional support
- Supports patient understanding, leading to patient problem-solving and decision-making
- Promotes a positive environment when delivering bad news
- Supports a respectful environment that promotes human dignity
- Allows for information giving that supports self-management and decision-making
- Promotes holistic patient care.

Based on the thematic analysis of the study objectives and their supporting global themes, results support the overarching concept that "the experiences of the nurse practitioner when delivering bad news to cancer patients are shaped by their own communication skills."

DISCUSSION

This type of qualitative research is of great value in generating an understanding of how utilizing the SPIKES protocol positively impacts how NPs deliver bad news to patients. The resulting themes suggest this tool is as useful for MDs as it is for NPs. These findings support that communication training and using a standardized tool play an important part in improving not only patient experiences but also provider experiences. Although PAs were not included in this research sample, it is reasonable to conclude they too would benefit from additional communication training and use of a protocol to help them compassionately deliver bad news.

Communication training should be included in all providers' educational programs and often

is now standard; however, since providers shape their own experiences, this research implies that repeat education and training in communication (beyond initial introduction of the concept in pre-licensure and graduate programs) may be necessary to hone providers' skills and facilitate holistic patient care. Limitations of this study include the following: (1) its small sample size; (2) participants consisted of only female NPs; (3) it is from one geographic area; (4) it focused on private practice; (5) the ages of the participants is similar; thus, the findings may not be generalizable to other practitioners, genders, and practice settings. Additionally, there may be a bias, as participants may have wanted to please the researchers. Future research should replicate this study with physician assistants as well as represent a more diverse mix of gender, ages, and geographic areas. Examining whether the use of this tool improved confidence for all health-care providers, the relationship of provider burnout, and occupational commitment to communication skills training are other areas of opportunity for new research.

CONCLUSION

Delivering bad news is an unavoidable part of an oncology practitioner's role. Promoting emotional support of patients while improving the experience for practitioners is essential. As self-reported, all five participants indicated they would continue to use the protocol, teach its methods to their peers in practice, and recommend it to others. ●

Disclosure

Dr. Corey has no potential conflicts of interest to disclose. Dr. Gwyn is on the speakers bureau for Incyte and Celgene.

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