

# Communicating Bad News: Using Role-Play to Teach Nursing Students

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## Abstract

Receiving bad news can have a profound impact on a patient's physical, psychological and social well-being. Therefore, communication of bad news is an essential skill required for health professionals. A good interpersonal relationship based on trust, empathy, and respect can help the psychological adjustment to end-of-life losses. This study presents a simulation-based learning experience designed to teach communication skills to nursing students who care for palliative patients and their family members. The authors suggest adopting Gibbs' reflective cycle during structured debriefing that enables the students to move logically through the reflective process. A student-centered learning approach can promote responsibility and success in achieving the expected learning outcomes.

## Keywords

communication, palliative care, role-play, reflective practice

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## Introduction

Communication skills in palliative care nursing, more than something that occurs naturally, is a complex achievement like other professional procedures that require intense education and practice (Blake & Blake, 2019; Smith et al., 2018). A particularly important and challenging nursing communication skill is the ability to “break bad news” to patients and families (ELNEC, 2016). There is a generalized need for specialized communication skills in nursing care, but these acquire special importance in particularly difficult contexts, such as patients with life-limiting illnesses and palliative care.

## Background

Bad news can be understood as any information that negatively affects a person's view of the future (Rosenzweig, 2012; Warnock, 2014). Different people may interpret similar information as either good, bad, or neutral. The way of communicating bad news can greatly impact the experience of the disease and death process. If this news is given incorrectly, it may trigger misunderstandings, prolonged suffering, and resentment. In contrast, proper communication can generate understanding, acceptance, and adaptation. Lazarus and Folkman's (1984) model of stress

and coping suggests that discomfort felt by health professionals varies with their experience in giving bad news, perception of the disease's severity, or their partial feeling of responsibility for this bad news (Biggs et al., 2017). Inadequately breaking bad news can result in losing a patient's trust (Bumb et al., 2017), and in extreme cases, a patient's suicide (Bumb et al., 2017).

Communicating bad news is considered a complex task as it requires verbal, paraverbal, and nonverbal communication skills, but also implies responding to emotional reactions, involving the patient in decision-making, dealing with stress (of both the patient receiving the news and the professional giving the news), and attempting to give hope when the situation is dramatic. One of the most common evidence-based models for delivering bad news is the SPIKES protocol. Based on robust evidence, this patient-centered protocol

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provides a stepwise framework for difficult situations that involve bad news (Kaplan, 2010). Each letter represents a phase in a six-step sequence.

**S = Setting up the interview.** This first stage includes arranging the physical setting to provide privacy, allowing the involvement of significant others, and the self-preparation of the professional—including self-awareness (negative feelings and communicating skills).

**P = Perception.** In this stage, by asking open-ended questions, the focus should be on assessing the patient's information, feelings, and expectations.

**I = Invitation to disclose and discuss information,** assuming that not all patients express the desire for full information about their condition. In this step, we ask the patient what information they desire, how much details they want, and how they prefer information to be disclosed.

**K = sharing Knowledge and information,** starting by warning the patient there is bad news. In this phase, communication techniques should be used to help the patient process the information. Information should be given in small amounts, in short sentences, and plain language, rather than medical jargon.

**E = Emotions.** Addressing the patient's emotions with empathic responses, by identifying a patient's primary emotion and the reason for the emotion, and expressing the connection between the reason and the emotion. Nonverbal communication is well accepted when the patient's emotional response is intense.

**S = Summarize.** In this last step, it is important to summarize the situation and align with a patient's knowledge, expectation, and hopes. Establishing a clear strategy for the future with regard to the clinical situation will lessen uncertainty and the patient's anxiety toward the future (Kaplan, 2010).

Communication about EOL care issues, in accordance with the readiness and preferences of the patient and their relatives is essential. This task facilitates a person-centered interaction with the patient (Hafskjold et al., 2015). "Person-centeredness" has become an increasingly familiar term within health and social care globally and has been used to describe the standard of care that places the patient/client at the center of care delivery (McCance et al., 2011). The concept of person-centered care includes both the physical and psychosocial environment (Bökberg et al., 2019). Such care is created jointly as healthcare professionals engage a particular patient through a genuine dialogue to understand the person's experience of their situation (Österlind & Hénoc, 2021). Evidence suggests that there is a need to improve person-centered palliative care, which should focus on both the person's suffering and their capability (Bökberg et al., 2019; Ohlen et al., 2017).

Good communication is the key to a dignified response to all of the sick person's dimensions. Communication is present, to a greater or lesser degree, in all interactions, constituting a permanent, albeit invisible link between the nurse,

the patient, and his/her family. Moreover, empathic communication skills necessarily demand active listening, which will help the nurse explore the patient and family's perception of the illness or disease trajectory (Rosenzweig, 2012). For effective person-centered care to commence, continue, and achieve success, the nurse and patient should have a good interpersonal relationship. This requires valuing oneself, promoting moral integrity and reflective ability, and knowing oneself—as the result of reflection—and about values of others and their place in the relationship (Rønning & Bjørkly, 2019). For nurses to achieve competency in conveying bad news, they must develop instruments that fully respond to this type of intervention.

The role of nurses in breaking bad news is largely unacknowledged and undervalued. However, they play an important role in this regard, for instance, by providing information and helping patients prepare for, receive, understand, and cope with bad news. Breaking bad news for the first time can be a terrifying prospect for students and novice nurses because they can feel guilt or a sense of failure that they have not "fixed things" for patients—even when they know that is an unrealistic expectation of their own role or ability to influence outcomes. Evidence shows that undergraduate nursing students are inadequately prepared to deliver palliative care (Kirkpatrick et al., 2017). Hence, examining the impact of EOL simulations with newly graduated nurses is needed to address this known gap. Palliative care education needs to focus on two key elements: self-directed and problem-based learning. Both can produce clear benefits by increasing critical thinking, problem-solving, and communication at multiprofessional levels. If ill-trained, nurses can face many problems during clinical practice. They are often expected to understand the needs of the patient and family members and tend to provide additional information after patients speak with the doctor, and their responses foster communication among all parties (Smith et al., 2018).

Several publications highlight the importance of communication techniques when delivering bad news to patients with life-limiting illness and their family members (Bousquet et al., 2015; Bumb et al., 2017). Despite the available evidence, many nurses feel inadequately trained to communicate bad news to patients and families in their practice. In nursing education, training communication skills using simulations has been revealed as more crucial—than merely teaching therapeutic techniques to increase self-confidence among nursing students—when communicating therapeutically with patients and families (Blake & Blake, 2019). Despite this, there are few studies about learning exercises for nursing students on how to break bad news (Erawati, 2017). Training with well-developed exercises is crucial to reach competency in this challenging situation.

This article presents a pilot role-play simulation conducted in a Portuguese undergraduate nursing program with senior students during an EOL simulation. Based on the study carried out by Mariolis and McKew (2020), the

simulation was designed to help nursing students develop communication skills necessary to care for patients receiving palliative and EOL care, and their families. The pedagogical approach had three main learning objectives: (a) improve student ability to break bad news and build their confidence in that ability, (b) increase use of empathic communication (understanding the patient's perception) to decrease uncertainty and patient anxiety; and (c) help students reflect on the experience.

## Method

### *Participant Recruitment*

The participants of this study were fourth-year students in the seventh semester ( $n = 30$ ) from a palliative care nursing course. Participation was mandatory and students had no previous experience with role-play simulation. The simulation was conducted in September 2020 and took place during three separate theoretical-practical classes, each with ten students. Student participation implied no additional compensation. The authors obtained consent from each participant to collect notes during the debriefing process and to use the project's results.

### *Role Assignment and Procedures*

Before each role-play, three students were randomly attributed the role of a nurse, patient, and family member. Students who were not assigned an active role observed the simulation and helped their peers on request. The exercise was followed by a debriefing period, when all students provided feedback with the aid of a facilitator. Three nursing educators (the authors) supervised student performance and took notes. Each session lasted 30 min and was followed immediately by a 20-min reflective thinking session (debriefing).

### *Clinical Scenario*

The simulation laboratory was organized to mimic the reality of a clinical environment. Before the simulation activity, the authors provided the role-players with a detailed script including dialogue, the clinical nature of the illness, and behaviors to be dramatized. Besides, the authors underwent a prebriefing session with each group of students, providing guidelines on the simulation environment and indicating student objectives. During the simulation, the students were expected to: (a) use principles of effective nursing communication skills in palliative care, such as breaking bad news; (b) implement the SPIKES communication model; (c) respond empathically to emotional distress; and (d) collaborate with peers by using the decision-making process and applying the course concepts in a real-life situation. In these role-play sessions, students could learn about the legitimacy, and

sometimes the urgency of other people's perspectives that are not always included in the decision-making process. The aim is not only to teach students to become aware of the different dimensions in decision making, but also to encourage them to think about what a framework for responsible action might look like.

A case vignette of a patient with palliative care needs was created. Manuel is a 38-year-old white man who presents constant and intense headaches, accompanied by uncontrollable vomiting, delirium, and blurred vision. He was diagnosed with an end-stage brain tumor. His prognosis was poor, and his wife was called so she could be present and provide support when he received the diagnosis. Sofia exhibited signs of stress and anxiety about the severity of her husband's health problems. Understandably, both Mr. Manuel and his family were devastated.

## Findings

Most of the students were females ( $n = 22$ ) aged between 18 and 25 years. During the debriefing session, students felt positive about their experience and performance, indicating that the simulation had promoted the development of cognitive (consolidation of theoretical knowledge), interpersonal (facilitation of therapeutic alliance), and affective (exploration of feelings) competencies. The intention of reducing the patient's and family's suffering and despair triggered various feelings among students, such as failure, anxiety, disappointment, impotence, nervousness, sadness, pity, compassion, revolt, and anguish. For that reason, students described conveying bad news as a complex process that required nurses to have a deep sensitivity, empathy, professionalism, and severe training. They accepted that one may not always be able to provide the best answer to a patient's needs—because it is also a singular and intense experience for the nurse—but that they must properly develop their communication skills (whether verbal or nonverbal) to provide the best support for the sick person and their family, while moving away emotionally from those who expect their support. Besides, descriptions of teamwork represent a pivotal experience for many students. Collaboration with peers during simulation provided insight into what teamwork should entail.

## Discussion

After each role-playing session, there was a group discussion and a debriefing with a facilitator, using a participant-centered positive feedback model (Abualhajja, 2019). Students were encouraged to explore and reflect on issues related to the communication of bad news using Gibbs' reflective cycle. The use of a model such as Gibbs' cycle enables the student to move logically through the reflective process and provides a structured approach. It offers a framework to examine experiences, and considering its cyclic

nature, lends itself particularly well to repeated experiences, allowing students to learn and plan based on good or bad past experiences (Jayatilleke & Mackie, 2013). The process includes six steps, namely: (a) describing the experience; (b) expressing feelings and thoughts about the experience; (c) evaluating the experience; (d) making sense of the situation; (e) concluding what was learned and could have been performed differently; and (f) elaborating an action plan to deal with similar situations in the future, based on high-quality evidence in palliative care.

Overall, students acknowledged that they felt nervous and lacked self-confidence in their abilities to communicate effectively, in accordance with previous research by Blake and Blake (2019). According to these authors, students feel more confident and comfortable while communicating bad news after the experience in simulation classes. However, students indicated that the number of hours dedicated to simulation is short, and more simulation classes are needed to improve the sense of self-efficacy and self-confidence in communicating sensitive issues, such as breaking bad news.

In our simulation experience, students felt more prepared to meet the patient's bodily and biological needs than their spiritual and psychosocial needs. This illustrates how physical and mental health care can often be disconnected and underlines the need for a more integrated approach (Daset et al., 2016). These results are similar to those of Mariolis and McKew (2020), who noted that lessons learned within simulation experiences could influence transfer to practice and enable communication with patients and their relatives. Furthermore, students reported that effective feedback is also important for learning, which can occur when contrasting personal perception of their performance with another person's perception. They also understood the value of teamwork, as it facilitated the decision-making process. Effective teamwork gave students chances to examine the patient's situation and the nursing interventions that should be taken (Handeland et al., 2021). Rønning and Bjørkly (2019) outlined how role-play prepares nursing students for complex clinical scenarios and helps them to switch from "an individual- and symptom-oriented focus to a focus on interpersonal relationships" (p. 417). Placing the student at the center of the feedback process may influence the dynamic of the interaction, and in turn, the outcome of learning.

### Limitations

Despite these promising findings, some limitations should be highlighted. First, the study had a small sample size and participants were selected by convenience sampling. Similarly, we conducted a pilot study where the results may not be generalized to real-life clinical scenarios. Although the results suggest that role-playing could be effective for learning outcomes of nursing students, further studies should compare the role-play method with other training methods—with

regard to their impact on the long-term learning of nursing students. Comparing effects on student anxiety, self-awareness, and emotion regulation of active versus observer roles in undergraduate nursing EOL care simulations would also be useful.

### Implications

A comprehensive palliative care curriculum focused on competency development should be the goal of every nursing school worldwide. Education and training on how to break bad news, in particular with role-playing exercises, can allow students to experience and understand a patient by experiencing their viewpoint (Blake & Blake, 2019). The student, thereby, develops a greater capacity for treating others with the respect and understanding required in palliative care nursing (Rønning & Bjørkly, 2019). This pedagogical exercise does not eliminate or decrease the educator's role, but rather should promote collaboration and facilitation between educator and learner. McCabe and O'Connor (2014) stressed that a student-centered learning approach includes four critical criteria: active accountability for learning, autonomous knowledge construction, proactive management of the learning experience, and educators as facilitators.

### Conclusion

Communication is, therefore, essential to build a relationship based on trust between patients and health professionals. This is particularly relevant in the case of distressing news because coping strategies can only be promoted if skillful communication takes place (Mariolis & McKew, 2020; Rønning & Bjørkly, 2019). Compassionate communication can be fostered if it is viewed as a technique inherent to the profession—one that requires considerable expertise and prudence, and that must be developed and shaped to become an integral part of the performance of health professionals. Although health professionals rely on a standard protocol to transmit bad news, they should consider each patient as a unique individual with particular biopsychosocial characteristics inserted in a specific environment.

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