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IMPROVING PATIENT-PROVIDER COMMUNICATION IN THE HEALTH CARE

CONTEXT

By

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Professional Paper

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in Fine Arts and Humanities, Communication Studies

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ABSTRACT

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Improving Patient-Provider Communication in the Health Care Context

Chairperson: Stephen Yoshimura

The following study focuses on ways in which health care providers seem to competently breaking bad news to patients that are college age (18-25yrs old). Breaking bad news is an inevitable and daunting part of working in the health care profession. Delivering this type of news to college age students could occur more frequently than with other cohorts. Buckman (1992) presents methodology for teaching breaking bad news to health care providers in the form of the SPIKES model, which are similar to the identified “essential elements” of communication in medical encounters described by communication scholars (Makoul, 2001). Several interviews were conducted with college age participants who had bad news broken to them by a health care provider. These bad news situations ranged from STDs, death of a family member, life long illness, and sport injuries. Two over arching themes of effective and ineffective ways to break bad news were present in the data; the sub-categories of express caring and being direct were shown as effective ways to break bad news to college age students and robotic and non-responsive as ineffective. The findings presented in this study can provide health care providers with insight on how to improve communication skills when working with college age patients.

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Improving Patient-Provider Communication in the Health Care Context

Charlotte Glidden

The University of Montana

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Introduction

The present study focuses on the communication issue of breaking bad news. Effective patient-provider communication can lead to successful health outcomes, improved quality of life, or deviation from the treatment plan, and termination of the professional relationship (Wright, Sparks & O’Hair, 2008). The present study focuses on communication within the patient-provider relationship, specifically as it occurs between health care providers and college age students (students ranging from age 18-26). Half of new sexually transmitted disease (STD) infections occur among young people in high school and college even though this age is only a quarter of the sexually active population (CDC, 2011). Breaking bad news about contraction of an STD is a fairly common occurrence in a health care facility that caters to University students. In addition to STDs, college athletes looking to go professional run the risk of injury that could potentially end the vision of a professional athletic career. The frequent occurrences of breaking bad news in the healthcare context and the particular age group that is most likely to receive bad news are further justification for the present study. Information from this study could be used to design a training curriculum for health centers that would contribute to the betterment of the students utilizing the facility, and arguably elevate the confidence level of the providers finding themselves in situations where they need to break bad news.

This study addresses the specific communication issue of breaking bad news to college age students that health care providers regularly face. This study intended to accomplish two overarching goals. The first goal was to expand the existing knowledge of breaking bad news techniques for health care providers. The second goal is to provide health care providers the tools necessary to effectively communicate with college age students.

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Provided below is the overview and rationale for the present study, and a brief discussion on the importance of education for the improvement of patient-provider communication. A discussion of the communication issue being addressed and an overview of methods for data collection and analysis are also discussed. Finally, results and the practical implications and limitations of the study are presented.

Overview and Rationale

Research reveals benefits of effective patient-provider communication (Wright, Sparks, & O’Hair, 2008). Yet, communication skills training is a relatively underdeveloped part of the medical/healthcare curriculum. Health practitioners may resist efforts to work with academic health communicators because of previous experiences, or stereotypes about academic researchers who have never been “in the field” (Parrott & Steiner, 2003). Further research shows that effective communication training within the patient provider relationship should be continual to increase effectiveness (Beckman & Frankel, 2003). This study would provide the opportunity for continuing education in the realm of effective communication in the context of the patient-provider relationship by collecting data from patients regarding the most effective and ineffective ways of breaking bad news.

Effective provider communication skill is linked to positive health outcomes for patients, including improved compliance, and increased physical and psychological health (Stewart, 1995). Additionally, the quality of the communication may set the tone for future interactions between the physician and patient (Sparks, 2007). Currently, most health care institutions do not have regular training sessions for health care providers to address patient-provider communication. This means that health care providers are left to cope with the challenges of deciding what is and is not effective communication with patients on their own, which is the case in most professional

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health care settings (Parrott & Steiner, 2003). The present study would provide adequate information on effective communication skills for breaking bad news to college age students.

Review of Literature

Breaking Bad News

Bad news is defined as “any news that drastically and negatively limits the patients view of their future” (Bor & Miller, 1993; Buckman 1992). Bor and Miller (1993) further detail bad news as, “... situations where there is either a feeling of no hope, a threat to a person’s mental or physical well-being, [or] a risk of upsetting an established life style.” (p. 2). This description is both useful and inclusive, as the judgment of information to be good or bad comes from the provider or receiver of that information in context (Bor & Miller, 1993). News of a sprained ankle would affect a student athlete wishing to play in a championship game in a much more negative way than it would a student who intended to sit and watch the game from the bleachers. Thus, the definition allows for perception and context as well as disease, injury or loss.

Delivering bad news can be daunting for health care providers (Buckman, 1992; Rosenbaum, Ferguson & Lobas, 2004). Health care providers can often seem cold or insensitive, but in the great majority of these cases, the health care providers are uncomfortable, on edge, or embarrassed (Buckman, 1992). Some dissatisfaction can be attributed to the news itself. Thus, the health care provider is simply the bearer of bad news, and suffers the reverberating effects. Buckman (1992) points out that this daunting experience is not an optional addition to health care providers’ special abilities, but is a mandatory part of their basic skills due to the frequency of its occurrence. Bad news will inevitably be delivered in the health context, and whether or not it is done well has a consequence. Reports show that patients had significantly more negative feelings toward practitioners when they felt bad news was delivered in an inappropriate manner

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(Girgis & Sanson-Fisher, 1998). Beckman and Frankel (2003) believe that lack of skill in delivering bad news is the result of well-intentioned clinicians finding themselves in environments that do not encourage reflection on the process of patient-provider communication or provide the opportunity to improve practical skills. Breaking bad news (BBN) is a frequent occurrence for healthcare providers, and the data collected will increase provider knowledge with this daunting experience and intends to set a ripple effect for positively affecting the patient experience.

Competent Communication in the Patient-Provider Relationship

Competent communication is concerned with “the extent to which objectives functionally related to communication are fulfilled through cooperative interaction appropriate to the interpersonal context.” (Spitzberg & Cupach, 1984, p. 100). Therefore, relationally competent communication is a function of process and outcome. In this case, process refers to the construction of the message with items such as context and appropriateness. Outcome refers to the perceived effectiveness of the message, or whether or not the goals of the interactants were achieved (Spitzberg & Cupach 1984).

Communication competence with breaking bad news to patients has been assessed in several studies. Munoz Sastre et al. (2011) provided a lay audience with fictitious accounts of health care providers breaking bad news, and asked them to score the provider’s message to the patient on acceptability. The findings showed that individuals tended to prefer strong quality of information, coupled with perception of emotional support of all the scenarios and that the process of providing information was ranked independently of content (Munoz Sastre et al., 2011). This means that regardless of the specific bad news being broken (in these cases: infection by the hepatitis C virus, cirrhosis of the liver, or cancer of the liver), participants were more

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concerned with how that message was being delivered by the physician. In this particular case, participants ranked messages where the health care provider was perceived to give more emotional support as the most desired message delivery style. Other studies indicate that patients prefer a health care provider that is sitting while working with them versus standing or moving about the room (Roter et al., 2006; Swayden et al., 2012). This preference is due to the fact that patients feel as though the health care provider is spending more time with them, and they feel less rushed (Roter et al., 2006; Swayden et al., 2012).

During a three-day conference based in Kalamazoo, MI, 21 major medical education and professional organizations attended an invitational conference jointly sponsored by the Bayer Institute for Health Care Communication and the Fetzer Institute. A main function of the convention was to identify a coherent set of essential elements in physician-patient communication, in order to develop more specific standards in regards to competent communication in the health care context. Professor Gregory Makoul, PhD, Director of the Communication and Medicine program at Northwestern University Medical School, provided leadership in writing the consensus of ideas that was developed during the Kalamazoo convention.

Seven elements of competent communication have been identified within the health care context (Makoul, 2001). Makoul argues that the first of these elements is to *build a relationship*. This element endorses patient-centered, or relationship-centered, approach to care, which includes the task of collecting information from the patient as well as balancing an awareness of the individual's feelings, ideas, and values. The second element is *open the discussion*, which includes eliciting the patients full set of concerns with emphasis on allowing the patient to complete his or her statements. The third element is to *gather information*. The health care

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provider is considered a competent communicator with this element if they use open and close-ended questions appropriately, although when that would be is not specified. The health care provider is also instructed to use active listening skills and structure, clarify, and summarize information received. The fourth element is *understand the patient's perspective*, which involves considering the context (i.e. culture, gender, age, socioeconomic status, spirituality), beliefs and concerns about health and illness, as well as acknowledging and responding to patients ideas, feelings and values. The fifth element of competently communicating in the health care context is *sharing information* in language the patient can understand and encourage questions. The sixth is *reach agreement on problems and plans* where the health care provider encourages the patient to participate in decisions to the extent he or she desires, and identifying resources for the patient. The final element identified is *providing closure*, here the health care provider summarizes the information and discusses a follow-up plan of action. These elements provide a framework for teaching breaking bad news to health care providers.

Analysis of communication competence literature is beneficial to the present study as it provides a framework of what has been known to work in the past. The studies on communication competence in the medical context discussed above were not described as being specific to a particular age group. The present study seeks to determine whether the previous findings are relevant when breaking bad news, competently and effectively, to a college age student. Below is a review of the current literature relevant to this topic.

Current Ways for Teaching How to Break Bad News

Rosenbaum et al. (2004) concluded that the most effective interventions present basic steps to effectively deliver bad news, provide opportunities for learners to discuss concerns, practice, and receive feedback on their skills. Buckman (1992) developed a 6-step process for

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BBN that provides an effective tool for enhancing health-care provider's communication skills, as well as the basic steps in breaking bad news (Rosenbaum, Ferguson, & Lobas, 2004). The 6-step process developed by Buckman (1992) has been presented in more contemporary research under the acronym "SPIKES" (see Appendix A).

The first "S" of the acronym stands for *setting*; this step stresses choosing a place to BBN that is private, comfortable for the patient, lack of time constraints and sitting down or being at patient eye-level. Patients are more receptive to health care providers who sit at the bedside than those who stand (Buckman, 1992; Swayden et. al, 2012). The letter "P" represents the patient's *perception* of the health issue. In this step the health care provider would ask questions such as "When you first had symptom X, what did you think it might be?" or "Did you think something serious was going on when...?" (Buckman, 1992). The letter "I" is for *invitation* and in this step health care providers are asked to obtain the patients invitation to describe the medical condition further. "K" represents the word *knowledge*. The health care provider should provide information in small chunks, check for understanding, and use lay terms. The letter "E" is the provider's reminder to *empathize and explore emotions* expressed by the patient. Buckman (1992) states that the success or failure of the BBN ultimately depends on how the patient reacts and how the provider responds to those feelings. The final "S" in the acronym stands for *summary and strategy*. The final step is to discuss a follow-up appointment and to remind the patient of what was discussed.

The SPIKES model for breaking bad news provides the basic steps to effectively deliver bad news, which is part of a successful intervention as discussed in Rosenbaum et al. (2004). The SPIKES model also closely parallels current literature regarding competent communication in the health care context (Makoul, 2001). At the time of this study, the SPIKES model has not

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been formally assessed. However, research shows that this 6-step process can be difficult to recall after the training session has ended (Bonnaud-Antignac, 2010). Nonetheless, health care providers reflection on and receiving ideas regarding more positive ways to break bad news is a vital step toward improvement upon existing skills (Bonnaud-Antignac, 2010; Schildmann, 2012), which is one of the goals of the present study.

Small group discussion and peer role-play are effective tools for teaching BBN. Researchers have utilized group discussion as way to grasp the learner's practical concerns regarding "psychosocial" aspects of the job and the group's language for expressing it (Beckman & Frankel, 2003). In a review of teaching techniques used for breaking bad news, highlighting advantages and disadvantages of each method, Rosenbaum et al. (2004) noted that small group discussions provide health care providers with the opportunity to discuss issues, skills, and concerns with one another. However, with group discussion there is not an opportunity for practice or feedback of BBN; incorporation of peer role-play would provide health care providers with the chance to practice BBN aloud and give/receive feedback.

An additional effective tool for enhancing health-care provider's communication skills is utilizing teachable moments (Rosenbaum, Ferguson, & Lobas, 2004). BBN is a frequently occurring issue and health care providers have ample opportunities to teach and reinforce skills for delivering bad news in the direct context of clinical care, these moments are referred to as *teachable moments*. Rosenbaum et al. (2004) provides an example of such a moment: "Before a bad-news encounter, faculty members can discuss concerns and possible approaches to bad-news delivery. They can ask the learner(s) about their experiences and concerns regarding delivering bad news, and thus assess their learning needs and levels of comfort with the task." (p. 113-114). In context of regular clinical rotations more experienced staff members can aid

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learners in honing their skills with breaking bad news. Incorporating ways to identify these teachable moments into a training curriculum would allow health care providers the chance to focus on BBN communication skills with more longevity. Re-visiting such trainings overtime to reinforce the tools provided to health care faculty and staff is important in reinforcing and improving upon classroom learning because health care providers will have the opportunity to re-visit what was learned in the training session (Beckman & Frankel, 2003; Cegala, 2006). Giving health care providers the opportunity to practice breaking bad news in a classroom setting, receive immediate feedback, as well as the opportunity to re-visit these types of trainings in the ways discussed above seem to be described in the literature as the most beneficial ways to learn how to effectively break bad news to patients.

Summary

Bad news is defined as “any news that drastically and negatively limits the patients view of their future” (Bor & Miller, 1993; Buckman 1992). This definition allows both for perception and context to be taken into account when determining what is or isn’t bad news for a patient. Context, as well as the message constructed, are both critical components of determining what is competent communication within the health care context. Contemporary research (Mikoul, 2001) has identified seven elements essential for competent communication that parallel the SPIKES model for breaking bad news (Buckman, 1992). Noteworthy similarities that exist include taking into account emotion and reason for emotions the patient is having, speaking to the patient in words they understand, giving the patient information as they seem ready/willing for it, and devising a plan for follow-up and care of the patient.

The most effective training sessions for BBN present basic steps to effectively deliver bad news, provide opportunities for learners to discuss concerns, practice, receive feedback on

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their skills as well as the opportunity to re-visit the training within the clinical setting (Rosenbaum et al., 2004). There is a need for additional knowledge on breaking bad news to the specific group of college age students. As discussed above, this age group is at high risk for an abundance of medical issues, and breaking bad news occurs frequently with members of this cohort. Additionally, because of the specific age group being discussed in the study the bad news being broken can arguably be more unexpected than other age groups. The present study intends to collect data from patients on their perceptions of what are (in)effective ways of breaking bad news. Through interviews with participants that have had bad news broken to them the present study intends to answer the following research questions:

RQ1: What tactics do patients identify as positive or effective ways to have bad news broken to them?

RQ2: What tactics do patients identify as negative or ineffective ways to have bad news broken to them?

RQ3: Among the positive and negative tactics used by health care providers, which tactics are most frequently reported?

Method

Participants and Data Collection

Seven participants were recruited using a network-snowball sampling method. Snowball sampling is an effective way to engage people on a sensitive subject (Lindlof & Taylor, 2002), such as bad news being broken in a health care context. Individuals who are minors (under age 18) and/or members of physically, psychologically or socially vulnerable populations were not recruited. Participants reported having had bad news, as defined above, broken to them by a health care provider.

To evaluate BBN from a patient's perspective, semi-structured narrative interviews were conducted. Interviewing patients about their BBN experiences was chosen over self-reported questionnaire methods, because interviews offer the opportunity to probe deeper into the narrative provided. Participants were asked to sign an informed consent form (Appendix B) and an interview guide was utilized (Appendix C).

After receiving Human Subjects Review/Institutional Research Board approval to interview participants, interviews were conducted from June to July of 2012. Interviews lasted roughly 20 minutes, took place at the convenience of the participants, were recorded for accuracy, and transcribed for analysis; this yielded twenty-one pages of text. Interviews were conducted until reoccurring themes emerged. Participants were recruited across the upper mid-west of the United States. The participants were, on average, 20.85 years old ($SD = 0.89$). Four participants were female and three were male. All participants identified themselves as Caucasian. Two participants had bad news broken to them through mailed letters, one participant reported the bad news being broken over the phone, and all other interviewees described face-to-face interactions

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with their health care providers. There was no compensation provided to patients for participation in the study.

Analysis of Results

To assess the research questions, the analysis involved careful study of the qualitative data using a grounded theory approach (Lindlof & Taylor, 2002). The patient accounts reflect their perceptions of the interaction; therefore, the language used by participants guided the development of themes with short descriptors, which are known as vivo codes (Lindlof & Taylor, 2002). As a new theme presented itself, a comparative method was used to determine whether the new theme was present within any other patient interviews. Themes were sorted and compared until data were saturated.

The seven bad news accounts were examined using an inductive approach to sort and assess data based on message content, effective and ineffective ways of breaking bad news, and tactics for breaking bad news that seemed to be most frequently reported. The groups that emerged for effective ways of breaking bad news were similar to parts of the SPIKES model (Buckman, 1992). Appendix D includes four general types of bad news recounted by participants, which included death, diagnosis, potential diagnosis, and sports injuries. Data regarding tactics used for breaking bad news were organized based on four breaking bad news tactics that emerged from patient interviews: express caring, being direct, robotic, and non-responsive. In the next phase of analysis two general themes of effective and ineffective ways to break bad news emerged.

Results

The breaking bad news instances had occurred anywhere from three years to several months prior to the patient interview. Participants were easily able to recall the setting,

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individuals present in the room, and the general way in which the bad news was broken to them. No participant was able to recall the exact message the health provider gave when breaking the bad news. This is not alarming, as it is well established that as arousal and stress levels dramatically increase, like with reception of bad news, memory can deteriorate and fewer details are recalled, including events which occurred immediately prior to or following the high stress episode (Joseph, 1998). Aside from the effects of high stress, medicines the individual may be on can also alter the recollection of the bad news episode. One individual noted that the bad news was broken to him while he was still under the effects of morphine, which inevitably delayed his full reaction to the bad news:

“It didn’t hit me while I was talking to him but later that night when everyone was gone... and everything had worn off... I kind of broke down and cried a little bit and I was like ‘this sucks, this is gonna be a long time’ cause at that point I was in the best shape of my life and it just sucked knowing that I wasn’t going to be able to use my right arm.” (Male, 22).

While the specific messages provided by the health care providers were unable to be recalled the following general ways of presenting bad news were revealed through the patient interviews.

Effective Ways to Break Bad News

In regards to research question one, which was “What tactics do patients identify as positive or effective ways to have bad news broken to them,” two themes were identified: express caring and being direct.

Express caring. One female participant, age 23, described how she understood that there is a line between a professional relationship with your health care provider and being “friends” (see Appendix E). Much of the research on breaking bad news discusses various ways to express

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caring to the patient in various verbal (Buckman, 1992; Makoul, 2001; Rosenbaum, Ferguson, & Lobas, 2004) and non-verbal ways (Buckman, 1992; Roter et al., 2006; Swayden et. al, 2012) while keeping a professional distance. Ways to express caring include handing the patient tissues if he or she becomes emotional, sitting while breaking bad news, indicating that you are available for any and all questions (e.g. the patient does not feel rushed by the health care provider), or if appropriate comforting messages such as “Many people live full lives with this disease.” In the present study 100% of participants who had bad news broken to them either face-to-face or over the phone indicated that the doctor or nurses present expressed caring in some way. This caring was expressed by the health care provider reminding the patient that they were available if other questions arose, the patient reporting feeling that they did not feel rushed by the provider, the health care provider handed the patient tissues or by expressing understanding of upset emotions. For example, one participant stated “She really seemed like she wanted to be there for me if I thought of other questions... She kept saying ‘you can always call myself, or the nurses hotline, with questions’” (Female, 20).

All participants, regardless of how bad news was broken to them, indicated that it would be positive if the health care provider expressed caring in a professional way while breaking bad news. Sparks et al. (2007) found similar results with patients indicating that a health care provider that is able to properly express caring is more desirable when he or she is breaking bad news.

In summary, the literature and data collected for the present study seem fairly solid in the conclusion that breaking bad news is more effective with some sort of expressed care.

Being direct. Being direct with a patient is defined as an honest, educated, and straightforward approach to breaking the bad news. When exploring ways to effectively break

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bad news, this would fall under the “knowledge” step as described by the SPIKES model of BBN (Buckman, 1992), as well as the fifth element of competently communicating of *sharing information* in language the patient can understand and encourage questions (Makoul, 2001).

A participant recalled:

“he told us [grandpa] had a 9% chance of making a full recovery or something like that so it was pretty much... he was going to be a vegetable more than likely if we... if he had any sort of life after the stroke” (see Appendix E).

When asked about the perceived positives of the way in which the bad news was broken, the participant commented “he just was dead honest with us and said that he is not gonna have the same life anymore... it worked for us” (see Appendix E). Here the patient expresses appreciation for the health care provider in being “upfront” and stating that it worked for him. Another participant expressed the same gratitude for the honesty the health care exuded while breaking the bad news “He just was a super chill guy, super down to earth and kept a rolling conversation... He was like a real human being and real person just talking with me ya know?” (see Appendix E).

Previous research on breaking bad news indicates that being direct with patients may not always be an effective strategy in these types of interactions. Sparks et al. (2007) reported some patients who described a direct approach as unemotional or lacking professionalism. The present study found a similar reaction from patients, but this seemed to depend on the way in which the health care provider was being direct with the patient. For example, while most patients reported a favorable reaction to having the news broken to them in a direct way, one participant reported “Then she just said it ‘you could have endometriosis’ and that was the message, just that, like I was supposed to be ready for that” (Female, 23). In this case the patient seems to reflect on the

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shock that came from the news and it seems as though the health care provider delivered the news in a way that brought the patient directly to the shock. For a health care provider to be both direct and effective in breaking bad news, the individual must exude a level of human connection, or perception of caring by patient. When human connection or perception of caring by patient was absent, the health care provider was seen as cold, or “robotic.”

Ineffective Ways to Break Bad News

In regards to research question two, which was “What tactics do patients identify as negative or ineffective ways to have bad news broken to them,” two themes were identified: being robotic and non-responsive.

Robotic. For the present study, robotic communication essentially describes a health care provider that was perceived to be ignoring the “human factor,” this person was merely completing his or her job with perceived disregard for the receptor of the bad news. One participant stated, “She just came in and said all your symptoms match this so this is what it is... And when I tried saying that I had a different symptom, then I was wrong because that didn’t match what she thought I had” (see Appendix F). During this particular interview, the participant expressed dissatisfaction with not feeling validated and even admitted to non-adherence of treatment without notifying the physician stating, “I didn’t even ask her - I just quit taking the pills.” The distinction is that while the health care provider may have actually cared for their patient, the patient perceived a lack of caring on the physician’s behalf. Quirk et al. (2008) reported similar findings in patient dissatisfaction with feeling “hurried” or the patient feeling as though the health care provider did not “care” about them.

Non-responsive. Being non-responsive with a patient in the instances collected for study is when bad news is broken in a way that the individual can not immediately elicit a response

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from the health care provider (i.e. bad news was delivered via voice-mail, letter, or the like). This tactic for breaking bad news was described as the most undesirable. In the instances examined for this study, the patient is told the bad news and given either no additional information, insufficient information for the questions that arise, or information that he or she is unable to understand without further interpretation. According to one participant “Because they sent it in a letter there was no one to ask questions... no one to explain what was going to happen now or anything like that” (see Appendix F).

The SPIKES model indicates that in order to effectively break bad news, the health care provider must consider setting, the patients perception of the health issue, and elicit an invitation to break the news (Buckman, 1992). These three steps help the health care provider to not only set up a more favorable context for breaking bad news, but to also gain insight to the patients current state before delivering the information. The non-responsive tactic is undesirable, in that it fails to factor in context for the patient. One patient opened a letter informing her of a diagnosis of polycystic ovarian syndrome, a disease that severely limits the individual’s chances of having children, while she was on her way to a baby shower. This participant described her bitter feelings towards the timing of opening the letter, and also indicated that she never thought they would send her information “like that” in the mail. Another participant was also informed via “snail mail” of her diagnosis of thyroid cancer. This individual indicated that what made the news so difficult to take was that she was alone, the doctors office was closed, and her family was six hours away.

Breaking bad news through the mail may not be ideal for the patient, but is a practical option for health care providers. When considering the number of patients versus the number of staff in a hospital, breaking bad news through a letter may be the most efficient option. Another

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benefit to breaking bad news through a letter is that all the information is printed out for the individual to read through and reference later. Despite the benefits, participants in this study seem to react to this way of having bad news broken to them most negatively, and every participant indicated that they would prefer having someone to talk with.

Research question 3 asked, “Among the positive and negative tactics used by health care providers, which tactics are most frequently reported?” In the present study, the majority of individuals interviewed reported that the breaking of bad news done by the health care provider expressed that the news was delivered in a positive way. Seventy-one percent of participants indicated that the health care provider, either primary or other staff present, expressed care for the patient and was the most frequently reported tactic used to break bad news. This is in comparison to only 57% of participants reporting that the health care provider delivered the bad news in a direct fashion. Only 28% of participants reported the health care provider as non-responsive or as robotic; however, 100% of participants mentioned that breaking bad news in a non-responsive way (i.e. through a voice mail, letter, or e-mail) would be the worst way to break bad news.

Practical Implications and Future Directions

The data presented here will be useful for health care providers who are frequently faced with the challenge of breaking bad news to patients; specifically college-aged students. As noted earlier, the portion of the college-aged population (ages 18-25) is at highest risk for STDs (CDC, 2011), and college athletes are on the brink of heading into professional sports. As one participant stated, this population is additionally,

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“at a point where life feels like its beginning, but there is still so much life to live... so if something happens to us now we have to adjust to already having lived so long without it and prepare ourselves for living so much longer with it” (Female, 23).

The information presented in this study is beneficial for health care providers, educators, and trainers to gain a sense of what methods of breaking bad news may or may not work best with this specific population. Health care providers can read the real-life recollections of bad-news interactions within the study as well as patients perceptions of those interactions to help develop their communication strategies with college age students accordingly, with being direct and expressing care as the most effective ways to break bad news to this age group. Previous work conducted by Burgoon and Hall (1988) provides insight as to what the behavior may look like in expressing care of being direct with a patient during breaking bad news. These behaviors included showing interest in the topic at hand, trying to show the other how you are similar (i.e. I have been through this too, I know someone who has been through this, or I have seen others get through this), listening to the patient, or being responsive to the ideas the patient may have (Burgoon & Hall, 1988). One participant indicated that the health care provider seemed to only want to hear about symptoms that matched the original diagnosis made; at the time of the interview the participant was still convinced that there was potentially a misdiagnosis because of this lack of “care.”

Learning how to break bad news effectively is a valuable skill that is recognized as important in the health care profession. Currently, this particular type of health care communication is not a large focus in many health care institutions, and health care providers are, for the most part, left to develop these skills on their own (Parrott & Steiner, 2003). A huge benefit can be had from integrating patient-provider communication skills in the current course

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content for medical students. Without current knowledge of specific course requirements for health care providers while in school, a recommendation can be made for a stronger, or more equal, focus on the socioemotional aspect of healing versus the biological aspect. While both are equally important, it is the socioemotional, communicative competence, and emotional state of the patient that seem to dictate whether a patient will continue treatment with a specific health care provider, or even at all, as discussed above.

Effective provider communication skill is linked to positive health outcomes for patients, including improved compliance, and increased physical/psychological health and may set the tone for future interactions between the physician and patient (Sparks, 2007; Stewart, 1995). More training programs should be implemented for not only medical students, but also for practicing health care providers as the most effective training in patient-provider communication is that which is ongoing (Rosenbaum, Ferguson & Lobas, 2004). The data presented in this study would provide grounds for developing a training program in aiding health care professionals with breaking bad news to college age students.

The following recommendations are for individuals considering developing a training program for health care providers on how to effectively break bad news specifically to college age students. The first recommendation is to be prepared to answer questions the individual may have regarding the bad news. Nearly every participant mentioned that they had questions after the news was broken to them and health care providers that were able to spend time answering those questions were seen as favorable. Spending time answering questions also seemed to help the participant feel as though they "mattered" to the health care provider, which in turn could be seen as "expressed caring." As one participant stated,

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“She took all the time I needed and I never felt rushed, I got everything answered and she assured me I could call back with questions... it was nice because I knew what was going on and felt some more control over what was happening” (Female, 20).

A second recommendation is to be direct with information. All participants seemed appreciative of having the bad news broken to them directly without “beating around the bush” tactics. One male participant stated “they just said it is what it is and grandpa would never be the same if he survived... it helped get you into ‘what’s the next step’ mode” (male, 20). Another male indicated that if the health care providers were not direct the breaking bad news situation would have been worse. He stated “it would have been worse if they made it seem like it was going to be okay when we all knew it wasn’t” (male, 21) when speaking about his sports injury. Here we see examples of the health care providers directly telling the patients about the diagnosis; further into the interview we see that these health care providers are direct but also express care with the delivery of the message. One patient noted “He was trying to talk to me about the football game on the TV too because I was watching it when he came in, just keeping it casual, it made him seem more human and like the situation was going to be okay” (Male, 22); as discussed in Burgoon and Hall (1988) trying to seem similar to the other helps with creating a interpersonal connection which in this case was still professional.

To teach such skills, an instructor could have a bad news scenario in which health care providers construct various messages to break the news and have a group edit the responses to make them better, select and highlight the best responses, or describe why a certain message construction would not work well (Rosenbaum, Ferguson & Lobas, 2004).

A major limitation of this study is the homogeneity of the sample. All participants identified as Caucasian and resided across the upper mid-west. Researchers wishing to replicate

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the present study may consider a more diverse sampling from various parts of the nation.

However, the purpose of this study was only to describe some impressions of medical “bad news” that college students have developed in their experiences. Despite this limitation, the data reflect the naturalistic recollections of some people with personal experiences relevant to the question, and are thus valuable in a descriptive way.

Breaking bad news to patients is surely not why individuals choose to enter the health care profession; however, it is an inevitable “part of the job.” While the present study, or any other study similar in nature, cannot provide specific templates for construction of an effective way to break bad news, it arguably raises awareness of the difficulty of the task at hand and gets those who choose to read it thinking, “What would be a positive way to tell an individual this disheartening information?” This thought itself is a step forward in improving patient-provider communication, and a step towards ensuring the positive experience of the patient.

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Appendix A – SPIKES Model

Table 1

The SPIKES protocol for breaking bad news to patients*

<u>Step</u>	<u>Description of Task</u>
Setting	Establish patient rapport by creating an appropriate setting that provides privacy, patient comfort, uninterrupted time, setting at eye level, and inviting significant others (if desired).
Perception	Elicit the patient's perception of his or her problem.
Invitation	Obtain the patient's invitation to disclose details of the medical condition.
Knowledge	Provide information to the patient. Give information in small chunks, check for understanding, and frequently avoid medical jargon.
Empathize	Empathize and explore emotions expressed by the patient.
Summary and Strategy	Provide a summary of what you said and negotiate a strategy for treatment or follow-up.

*As presented in Rosenbaum, Ferguson & Lobas (2004).

Appendix B – Informed Consent Form

Breaking Bad News – A Patient Perspective

You are being asked to take part in a research study investigating effective ways to break “bad news” to patients. Bad news is defined as “any news that drastically and negatively limits the patient’s view of their future.” In other words, bad news is when you feel that your life’s options have been limited in some way (i.e. “I no longer have a shot at going professional with this sport” or “I won’t be well enough to take that job”).

While there is no direct benefit to you, this study is being conducted for the purpose of discovering effective and ineffective ways to break bad news to people between the ages of 18 and 25, and may in the future be used to develop a training program for health care providers on effective ways to break bad news. If you agree to participate in this interview, you will be asked to think about a time when you have had break bad news broken to you, how you felt about that experience, and advice you would have for people who must break bad news to others. The interviewer will ask you to recall a time when you had bad news broken to you by a health care provider and recalling this event may make you uncomfortable. Please do not continue if you feel uncomfortable.

Your decision to participate in this study is completely voluntary. If you decide to take part in this study, which is estimated to last roughly 20 minutes, you may withdraw from the study at anytime without any penalty. Please do not continue if you feel uncomfortable. Upon completing the interview you will be provided with information about helpful resources as well as researcher information.

Your participation in this study is confidential. Your name will not be disclosed to any person, organization, etc. for any reason. Only the researcher, research advisor, and other approved research members will have access to the data. The results of this research may be publicly presented and/or submitted for publication, but names will not be used.

Statement of Consent:

I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. I am aware that the interview will be recorded and transcribed for accuracy by the primary researcher. Furthermore, I have been assured that the researcher will also answer any future questions I may have. By participating in this interview I voluntarily agree to take part in this study.

Thank you!

Signature _____

Date _____

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If you should want any information regarding counseling in your community this information is below. This sheet is for you to take with you.

If you have any questions about the research after completing the interview, please contact **Charlotte Glidden** at (763) 260-0476 or Charlotte.Glidden@umontana.edu, or my research supervisor. Steve Yoshimura at either (406) 243-4951 or Stephen.yoshimura@umontana.edu. If you have any questions regarding your rights as a research participant, you may contact the Chair of the IRB through The University of Montana Research Office at (406) 243-6670.

Counseling and Health Services Information:

Cook Counseling Services

The City of Saint Cloud
605 25th Ave. So.
Saint Cloud, MN 56301
<http://www.cookcounselingmn.com>
Phone: (320) 223-0503

Counseling and Psychological Services

Saint Cloud State University
Stewart Hall 103
Saint Cloud, MN 56301
<http://www.stcloudstate.edu/counseling/>
Phone: (320) 308-3171

Appendix C- Interview Guide

- I. Collect the Narrative
 - a. Demographics
 - i. How old were you when they had the bad news broken to you?
 - ii. What was the sex of the health care provider?
 - b. Physical Information
 - i. Setting
 - ii. Positioning of doctor
 - c. What did the health care provider say when they broke the bad news?
 - d. Did you provide a reaction to the bad news?
 - i. Things said or done
 - e. Were there any other people in the room?
 - i. Relation to patient?
 - ii. What, if any, were their contributions to the situation?
 - iii. Do you think having these others in the room made a difference (good or bad) in the breaking of the bad news?
- II. Perception of the experience
 - a. Good
 - i. What do you feel the health care provider did that made this a positive experience?
 - b. Bad
 - i. What do you feel the health care provider did that made this a “negative” experience?
- III. Consideration of alternative experience
 - a. Good
 - i. How do you think this experience could have been turned into a negative one?
 - b. Bad
 - i. How do you think this experience could have been a more positive one?
- IV. Advice
 - a. What is some advice you might give to health care providers who have to break bad news to patients that are college age?

Appendix D – Patient Bad News Scenarios

Bad news content	Frequency	Conceptualization	Patient Account
Death	n = 1; 14.29%	Communication about death of a loved one	“If we decided to put him on life support he would probably be in a wheel chair, need constant care, his quality of life would have completely diminished.”
Diagnosis	n = 2; 28.57%	Affirmed diagnosis of a chronic disease	“The letter just stated that I have thyroid cancer.. And I’m 20 years old” “... and the news was that I had polycystic ovarian syndrome”
Potential Diagnosis	n = 2; 28.57%	Indicates need for further testing	“She told me my symptoms were an indication of endometriosis” “My yearly pap came back abnormal so she said I could possibly have HPV”
Sports injuries	n = 2; 28.57%	Injuries that mean end of season/sports career for athlete	“I got knocked out for like 30 minutes and came to and was like ‘its broken isn’t it’ to the guy and he was like ‘your arm is snapped in half’” “They brought me in on a stretcher, hooked me up to the game ready and we all knew the season was over for me”

Appendix E - Effective Ways to Break Bad News

Tactic	Frequency	Patient description of tactic	Content	Patient description of satisfaction
Being direct	Reported by n = 5; 71.42% participants as occurring Discussed as effective by n = 6; 85.71% participants	“he told us [grandpa] had a 9% chance of making a full recovery or something like that so it was pretty much... he was going to be a vegetable more than likely if we... if he had any sort of life after the stroke.”	Death	“he just was dead honest with us and said that he is not gonna have the same life anymore... it worked for us.”
		“You might have to have surgery, we are going to x-ray it, you are going to lose some functionality and your arm is maybe crooked for the rest of your life”	Sports injury	“He just was a super chill guy, super down to earth and kept a rolling conversation.. He was like a real human being and real person just talking with me ya know?”
Expressing caring	Reported by n = 6; 85.71% participants Discussed as effective by n = 7; 100% of participants	“I started crying and she acknowledged I was upset, she handed me tissues”	Potential Diagnosis	“I mean I understand there is a fine line between being your doctor and being your friend and that was her way of showing she cared which was nice”
		“They know me and they know how bad I wanted to play.. The main athletic trainer gave me a pat on the back and then he knew I needed space.”	Sports injury	“He just got me, he knew what I needed to hear.. Or not hear.. And knew the best way to go about it.. All I needed was that pat on the back, we both knew it was over anyways.”

Appendix F - Ineffective Ways to Break Bad News

Tactic	Frequency	Patient description of tactic	Content	Patient description of dissatisfaction
Robotic	Reported by n = 2; 28.57% participants as occurring Discussed as ineffective by n = 4; 57.14% participants	“She just came in and said all your symptoms match this so this is what it is.. And when I tried saying that I had a different symptom, then I was wrong because that didn’t match what she thought I had”	Diagnosis	“Its like me as a person didn’t even matter... I just have what I have and that’s it.. Now I’m in a box and anything outside this box she made for me doesn’t matter”
		“If he acted like he didn’t really care.. Like he was a robot or something.. Then that would have been bad”	Death	“Well you have to show you’re human, either in your tone of voice or how you’re moving around the room.. Lt us know you care some”
Non-Responsive	Reported by n = 2; 28.57% Discussed as ineffective by n = 5; 71.42%	“Because they sent it in a letter there was no one to ask questions.. No one to explain what was going to happen now or anything like that”	Diagnosis	“Opening the letter that tells you, you will basically never have kids and not knowing anything beyond that when you’re on your way to a baby shower is pretty ridiculous”
		“I mean being told over the phone wasn’t ideal but I had her on the line to answer questions.. It would have been worse if she left a voice mail”	Potential Diagnosis	“I think when you get left something like that in a voice mail there is this ‘so what happens now?’ question that you can’t answer and that’s scary because then your mind starts to go crazy with all these ‘What-ifs?!’”