

Ideal bad news delivery requires skilled communication and team support. The literature has primarily focused on patient preferences, impact on care decisions, healthcare roles, and communication styles, without addressing systematic implementation. This article describes how an interdisciplinary team, led by advanced practice nurses, developed and implemented a collaborative practice model to deliver bad news on a unit that had struggled with inconsistencies. Using evidence-based practices, the authors explored current processes, role perceptions and expectations, and perceived barriers to developing the model, which is now the standard of care and an example of interprofessional team collaboration across the healthcare system. This model for delivering bad news can be easily adapted to meet the needs of other clinical units.

AT A GLANCE

- The optimal delivery of bad news is an interprofessional and collaborative event.
- Delivery of bad news can be distressing to patients, families, and staff when not performed effectively.
- Advanced practice nurses have an opportunity to model positive behaviors that support the effective delivery of bad news.

KEYWORDS

bad news; communication; palliative care; end of life; cancer

DIGITAL OBJECT

IDENTIFIER

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Collaborative Practice Model

Improving the delivery of bad news

Pamela N. Bowman, BSN, RN, OCN®, Kim Slusser, MSN, RN, CHPN, NEA-BC, and Deborah "Hutch" Allen, PhD, RN, CNS, FNP-BC, AOCNP®

The delivery of bad news can be challenging for any member of the healthcare team for many reasons, ranging from personal beliefs to feelings of inadequacy or blame (Bumb, Keefe, Miller, & Overcash, 2017). The term *bad news* conjures negative thoughts and feelings, and bad news is often distressing for oncology practitioners who deliver it every day.

Some research indicates that the delivery of bad news should be a collaborative process (Baile, Buckman, Schapira, & Parker, 2006; Bumb et al., 2017). However, confounding factors (e.g., perceptions of staff availability, role expectations, experience, training) may prevent team coordination. When bad news is delivered without provision of the key elements for support and advocacy, the results can be devastating to the patient and family, as well as to the healthcare team (Brown, Parker, Furber, & Thomas, 2011).

This article describes the development and implementation of a collaborative practice model (CPM) to promote the optimal delivery of bad news on an inpatient medical oncology unit. The authors address staff perceptions of daily practice prior to the CPM intervention, barriers identified in the delivery of bad news, and steps involved in the development and adoption of the CPM intervention.

Literature Review

Bad news may be defined as any information that negatively affects an individual's perception or expectation for the future

(Barclay, Blackhall, & Tulskey, 2007). The delivery of bad news has been discussed since Buckman (1984) coined the phrase *breaking bad news*. The original five-year literature search, from 2006–2010, of the MEDLINE®, CINAHL®, and PsycINFO® databases produced 358 articles from these terms: *delivery*, *breaking*, *receiving*, *giving*, or *communicating bad news*. Three themes were identified from the literature:

- Patient and family perceptions of how bad news was presented and its impact on care decisions
- Roles of the healthcare team in the delivery of bad news and their perceptions of patient and family responses
- Healthcare training simulations for the delivery of bad news

Patient Preferences

Patients and families want honest and direct communication when bad news is delivered; all options should be discussed, including no treatment (Dougherty, 2010). Families perceive that less suffering and pain and an overall better end-of-life experience occur when bad news communications are good (Bumb et al., 2017; Parker, Aaron, & Baile, 2009). When a mismatch exists between patient/family expectations and healthcare team communications, distrust and negative care outcomes are the result (Dougherty, 2010).

Best Practices

Training healthcare teams in the delivery of bad news varies greatly, depending