Training for difficult conversations and breaking bad news over the phone in the emergency department

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ABSTRACT
Due to the COVID-19 pandemic, there have been strict limits on visitors to hospitals. This has led to clinicians having an increasing number of difficult conversations with patients and their relatives over the phone. There is a lack of published literature examining how to do this well, but it is recognised that phone communication does differ from face to face interactions, and requires specific training. What is most important to patients and their families when receiving bad news is privacy, adequate time without interruptions, clarity and honesty when delivering the information, and an empathetic and caring attitude. Much of the work done on breaking bad news has been done in oncology and focusses on face to face interaction; there has been an assumption that this is transferrable to the emergency department, and more recently that this is applicable to conversations over the phone. Multiple educational interventions to improve the delivery of bad news have been developed, with differing frameworks to help clinicians carry out this stressful task. Simulation is widely used to train clinicians to break bad news, and has solid theoretical foundations for its use. The psychological safety of participants must be considered, especially with emotive subjects such as breaking bad news. We believe there is a need for specific training in breaking bad news over the phone, and developed an innovative simulation-based session to address this. The training has been well received, and has also highlighted the need for a space where clinicians feel able to discuss the emotional impact of the difficult conversations they are having.

INTRODUCTION
The COVID-19 pandemic has led to strict limits on visitors to our hospitals. This means that some of the difficult conversations we usually have face to face with patients and their relatives are occurring over the phone instead. Using the phone for these conversations is more difficult, due to the characteristics of phone communication as well as a lack of training in this skill.[1] Breaking bad news is a stressful part of the job for clinicians, particularly when this involves patients who are dying.[2] How information is communicated to relatives can have a significant impact on the grieving process, and this is not always done well.[3 4] The Royal College of Emergency Medicine, Australasian College for Emergency Medicine and the European Society for Emergency Medicine all recommend training for staff in end of life care,[5–7] and multiple models and training courses have been developed to aid clinicians in these circumstances.[8 9] However, these have not necessarily been designed for the emergency department (ED), and generally do not include how to have these difficult conversations over the phone.

BREAKING BAD NEWS IN THE ED
Any news that provokes a negative reaction can be described as bad news, and this can differ depending on individual circumstances. However, the news of death or dying is universally acknowledged as bad.[8] Each patient, or their relative, will have preferences for how they want the news to be delivered, which depends on their individual circumstances, personality and culture. Despite this variation, there are some key areas where agreement occurs. These include ensuring privacy and adequate time without interruptions, clarity and honesty when delivering the information, and an empathetic and caring attitude.[8 10–12] Empathetic communication is particularly important for patients' psychological reactions to bad news.[13] In the ED, death, or an emergency presentation with a poor prognosis, is often unexpected and sudden. This creates specific challenges for staff delivering bad news. It is often the first interaction between the doctor and the patient or relatives, meaning there is very little time to build a relationship.[14] Patients and their relatives may be unprepared for this bad news, which can provoke disbelief, shock, hostility and fear as well as grief.[15]

Breaking bad news is challenging for clinicians, as it generally provokes negative emotions such as sadness, guilt and failure.[8] It can be difficult to gauge a patients' preference for how much information they would like and how quickly, and clinicians may fear many aspects of the process - not doing it well enough, extinguishing hope, being wrong about the prognosis and the patient's emotional response.[16] If in addition to these fears, a clinician does not feel confident in breaking bad news, they may avoid it or do it badly.

EMPATHY AND EMOTION
Empathy from healthcare professionals is valued by patients and their relatives, especially when breaking bad news.[8 10–13 16] In her paper describing 'Narrative Medicine' Charon places the need for empathetic care firmly at the centre of physician–patient relationships, urging doctors to not only be competent in the technical and academic aspects of their jobs.[17] Communication skills training may help clinicians to express emotion,[18] but it is not enough on its own. Kerasidou and Horn argue that for clinicians to be empathetic with their patients, they need to be supported to undertake this emotional work.[19] They describe the tension between the need to care for and empathise with patients, and the need to

maintain some emotional detachment. In addition to training in breaking bad news, there needs to be ongoing support through reflective sessions for clinicians to express and normalise their emotions.[20] This is particularly important during the COVID-19 pandemic. In addition to the negative emotions associated with breaking bad news, they suffer the moral injury and distress that comes with seeing patients deteriorate and die without their loved ones present.[21]

EXISTING FRAMEWORKS FOR BREAKING BAD NEWS

Several frameworks have been developed to help clinicians break bad news, but up to this point these have focused on face to face interaction. These frameworks can still be used in phone conversations, although the details of how they are applied may need to be modified. Having a structure may help clinicians feel more prepared and confident to have conversations in which they are breaking bad news, and are useful in this regard. However, their use relies on several assumptions. It is presumed that these conversations proceed in a stepwise manner, when this is not always the case.[22] In the training sessions we have run, we have found that using a framework can get in the way of an empathetic conversation. These conversations are often complex and require adaptability from the clinician to ensure they are responding to the patient in front of them, rather than rigidly sticking to a model. We would suggest that during initial training in breaking bad news it may be useful to employ a framework, but subsequent training is required to become more skilled in using these frameworks flexibly, or not at all.

One of the most commonly used frameworks for breaking bad news is 'SPIKES'.[9] This consists of six stages: Setting up the interview, assessing the patients Perception, obtaining the patient's Invitation, giving Knowledge and information to the patient, addressing the patient's Emotions with empathetic responses and finally Strategy and summary.[16] The model was designed for use with oncology patients, but has been used in a wide range of settings, including the ED.[23 24] Despite its widespread adoption, the authors are open about its limitations—the model is not completely evidence based, and whether patients actually find it helpful is a question that remains to be answered.[16] In the 20 years since this framework was published, only one paper has examined the effect of an intervention to improve the delivery of bad news on patient outcomes, rather than the effects on the participants.[9]

Fujimori et al designed an alternative model, SHARE, based on their previous work examining the preferences of Japanese oncology patients with regards to the breaking of bad news. This consists of S—setting up a supportive environment, H—consider how to deliver the bad news, A—giving additional information, answering questions, R—reassurance and E—empathy.[13] They found that patients of oncologists who underwent a 2-day course based on the SHARE model had increased levels of trust in their oncologist and reduced levels of depressive symptoms.

One of the few models that has been designed for the ED is 'GRI_EVING', for use when notifying relatives of a death.[25] This framework was developed from the existing literature, pulling out the important points to cover when speaking to a grieving family. The mnemonic consists of G for 'gather'—gather the family members, making sure that everyone who should be present is there; R for 'resources'—this can include people, such as a member of the clergy, or physical resources, such as written information for bereaved relatives; I for 'identify', it is important to identify not only yourself, but who has died, and who you are speaking to, as well as identifying what the relatives

already know of the situation; E for 'educate'—educate the relatives on the events that have occurred and how their loved one is currently (this should be brief); V for 'verify'—verify the death of their relative, using clear language such as 'dead' or 'died';_ is for 'space'—give the relatives space to take in the news and express emotion if they need to; I for 'inquire'—allow the relatives to ask any questions, and answer them as best you can; N for 'nuts and bolts'—cover the practicalities and next steps, consider asking about organ donation, and offer them the chance to spend some time with the deceased person; G for 'give'—ensure the family have contact details to allow them to get in touch with any questions they may have in future. Hobgood et al found that an educational intervention using this model improved the confidence and competence of Emergency Medicine residents in death notification.[25]

BREAKING BAD NEWS OVER THE PHONE

There is little empirical evidence on how best to break bad news over the phone, probably because both clinicians and patients prefer face to face consultations in this situation.[10 26] These conversations are more challenging to have over the phone, as all non-verbal forms of communication are lost.[26] In phone consultations, doctors are more likely to concentrate on factual information as opposed to the psychosocial context.[1 27] The loss of facial expressions and body language make it harder to express the empathy and support which is so important to patients when receiving bad news. There are also other more subtle losses, such as the warning shot of being taken into a quiet room, the comfort of being made a cup of tea, and not being alone after the news is delivered. The differences between phone communication and face to face conversations require specific skills and training.[1 28]

There has been some guidance published on breaking bad news during the current pandemic,[29 30] which suggest a few adaptations when doing this over the phone. When preparing to give the news, establish where the recipient of the phone call is, whether they can have an uninterrupted conversation, and whether they have anyone with them for support. Empathetic expression and tone of voice is emphasised, as is the use of silence. It is also recommended that thought is given to how the call will be concluded—ensuring information about the next steps after the phone call is available. This guidance is based on the best evidence available, but this evidence is not specific to phone conversations. It is in alignment with what patients want from these conversations, and is likely to be useful for clinicians.

EDUCATIONAL INTERVENTIONS FOR IMPROVING THE DELIVERY OF BAD NEWS

Educational interventions based around frameworks often include teaching on empathetic and clear communication. It may be that the improvement in communications skills is due to this, rather than the use of the framework itself. Much of the evidence for the use of frameworks is either self-reported confidence of participants, or competence as measured by observer rated simulated scenarios.[9 22] There is a risk that these ratings measure how well the participant uses the framework, rather than how well they have the conversation. There is limited evidence on how this training is used in clinical practice, and what effect it has on patients or their relatives.

Baile et al found a significant improvement in confidence when breaking bad news for participants of a workshop based on SPIKES,[16] and a systematic review found that educational interventions using the SPIKES model significantly improved

the delivery of bad news by clinicians in a variety of settings and specialties.[9] As discussed earlier, the ED has specific characteristics which differ from the oncology setting, but little has been published on interventions specifically tailored for the ED. Servotte *et al* studied the effect of a 4-hour training session for ED residents and medical students, which involved theoretical teaching of the SPIKES model and simulation scenarios.[24] They found their intervention improved self-efficacy, competence in using SPIKES, and communication skills more generally. A study on the GRI_EVING framework found that self-efficacy and competence significantly improved post-intervention, which consisted of a mini lecture, small group discussion and role play.[25] Additionally, this study measured interpersonal skills scored by an actor simulating a bereaved relative. The participants scored highly on interpersonal skills both pre-intervention and post-intervention, with no significant change seen. For both these studies, it is difficult to judge how much of an impact this training has for patients, as the use of these skills in clinical practice has not been measured. The lack of this evidence is understandable, due to the ethical and logistical issues of studying those who have recently received bad news. However, work in this area would be valuable to ensure we are training clinicians in the ED to do what our patients and their relatives actually need us to do.

USING SIMULATION IN BREAKING BAD NEWS TRAINING

The role of simulation within medical education is now well established, especially in terms of learning technical skills, and is used in the majority of the interventions to improve the delivery of bad news described in the literature.[9] The patient safety movement has been an advocate for simulation, and wider acceptance of it as a teaching modality was reinforced in the UK by the recommendations in Sir Liam Donaldson's Chief Medical Officer's Report of 2008.[31] This report noted the importance of this style of training as a route to safer patient care and called for it to be more fully integrated into the health service. One of the advantages of simulation is it allows participants to practice in a 'safe' environment, where patients will not come to harm. Gaba is most widely quoted in the literature when it comes to explaining the rationale for simulation training. He states that simulation is a technique 'to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion'.[32]

A number of pedagogical theories can be used to explain the use of simulation. Kneebone *et al* use the conceptual framework of Vygotsky's 'zone of proximal development' and later work on scaffolding; the theory being that learners work at the limits of their ability, under the guidance of those with pre-existing expertise, knowledge or skills.[33] Kolb's learning cycle has also been used to explain how learning occurs in simulation, the debrief helps the learners reflect on their experience and progress through the cycle.[34] This reflective process, with feedback from a more experienced and trained facilitator, is often not available in normal clinical practice. Breaking bad news is an example of a situation that is particularly suited to simulation, as learners rarely get a chance to practice this skill before they do it with patients. It is within what Chiniara *et al* describe as the 'Zone of Simulation'—a high acuity event (the possible impact on the patient or relative is severe), with low opportunity (the ability to practice this skill is limited).[35]

Simulation is frequently described within the literature as being 'risk free' for learners as well as patients, however this is not always the case. In 2013, the journal *Simulation in Healthcare* published an issue focusing on the potential challenges to the psyche of participants. In this issue Gaba reiterates the responsibilities of facilitators and trainers to consider the psychological effects on the participants, to encourage discussion in the field about this, and to act in the best interests of all those concerned when planning and delivering courses.[36] This is especially important when considering simulation training in an emotive area such as breaking bad news. Skilled and experienced faculty are required to plan and facilitate these kind of training sessions.

SIMULATION BASED TRAINING SESSION FOR BREAKING BAD NEWS OVER THE PHONE

In response to the need for training in having difficult conversations over the phone, we have designed and are running simulation-based sessions for clinicians in collaboration with Role Plays for Training (RPfT), a company specialising in drama-based training. Out of the group of participants, one is given a clinical scenario, and must call a patients' relative to break the news of a deterioration or death. The call is made to the actor on speakerphone, so the other participants in the session can hear both sides of the conversation. The actors we worked with have previously facilitated communication skills training and are practiced in giving detailed and sensitive feedback. After each conversation, the actor gives some focused feedback, before hanging up. At this point, the wider group debrief the conversation, facilitated by a member of faculty. It is a space for the participants to discuss the interaction and their own experiences. We do not advocate the use of a specific framework; instead we emphasise the importance of having an authentic conversation, prioritising what is important to relatives—honesty, clarity and empathy. We noticed that sometimes participants would try to stick to a framework, even when this was not what the simulated relative wanted or needed. Using actors, instead of medically trained faculty, to play the relative meant there was no knowledge or expectation of how the conversation would proceed. Both actors and faculty were not looking at how well a framework was used, but the overall communication skills required to do this difficult task well. We found that this flexible and individual approach was useful for our participants, who had generally already had training in breaking bad news which involved the use of a framework. Feedback and discussion during the debrief often covered preparation for the calls, the use of language and silence, and particularly the expression of empathy. This intervention has been well received by participants, and we are in the process of formally evaluating its impact.

CONCLUSIONS

The ED is a difficult place to break bad news, as the news is often unexpected and is coming from someone who has had little chance to build a relationship with the recipient. This is even harder over the phone, and comes with the additional moral distress from seeing patients dying without their loved ones around them. We believe specific training is required, which should focus on the key areas that are important to patients—preparing for the conversation, being clear and honest when delivering the news and answering questions, and particularly showing empathy and compassion—rather than following a specific framework. There is also a need to go beyond training clinicians to improve their delivery of bad news, and create a space for clinicians to discuss their emotional responses to this distressing aspects of their work.

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