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REVIEW

# Communicating bad news: an integrative review of the nursing literature

*Comunicação de más notícias: revisão integrativa de literatura na enfermagem*

*Comunicación de malas noticias: revisión integradora de literatura en enfermería*

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**ABSTRACT**

**Objectives:** describe how the process of breaking bad news is established and identify how nurses approach the task of giving bad news. **Method:** integrative review of the literature for articles in Portuguese and English published between 1993-2014, in the databases: Bireme, PubMed, Scopus, Web of Science, CINAHL and Embase. Nine articles were included using the selection flow chart. A digital form was completed for each article according to the Consolidated Criteria for Reporting Qualitative Research checklist and the level of scientific evidence was determined. **Results:** Of the 99 articles in identified, nine were included after applying the selection flowchart. **Discussion:** breaking bad news is frequent in the area of oncology and palliative care, with a strong cultural influence on the autonomy of nurses in this process. **Conclusion:** the approach and skills of the nurse during this task influences the patient's reaction to the message. The theme is scarce in the literature and merits further investigation.
**Descriptors:** Truth-Telling; Communication; Nursing; Family; Information.

**RESUMO**

**Objetivos:** Descrever como se estabelece o processo de comunicação de más notícias e identificar como o enfermeiro pratica a comunicação de más notícias. **Método:** Revisão integrativa da literatura com artigos em português e inglês referente ao período 1993-2014 nas bases de dados Bireme, PubMed, Scopus, Web of Science, CINAHL e Embase. Elegeram-se nove artigos pelo fluxograma de seleção. Para cada artigo foi preenchida uma ficha eletrônica, elaborado um *checklist* do Consolidated Criteria for Reporting Qualitative Research e verificado o nível de evidência científica. **Resultados:** Foram identificados 99 artigos e incluídos nove pelo fluxograma de seleção. **Discussão:** Transmitir más notícias é frequente nas áreas de oncologia e cuidados paliativos, com forte influência cultural na autonomia do enfermeiro nesse processo. **Conclusão:** O modo e a habilidade do enfermeiro durante a ação influenciarão a reação do paciente acerca da mensagem. O tema é escasso na literatura, necessitando ser explorado.
**Descritores:** Revelação da Verdade; Comunicação; Enfermagem; Família; Informação.

**RESUMEN**

**Objetivos:** Describir como se establece el proceso de comunicación de malas noticias e identificar como el enfermero practica la comunicación de malas noticias. **Método:** Revisión integradora de la literatura con artículos en portugués e inglés referente al período 1993-2014 en las bases de datos Bireme, PubMed, Scopus, Web of Science, CINAHL y Embase. Se eligió nueve artículos por el flujograma de selección. Para cada artículo fue rellenada una ficha electrónica, elaborado un *checklist* del Consolidated Criteria for Reporting Qualitative Research y verificado el nivel de evidencia científica. **Resultados:** Fueron identificados 99 artículos e incluidos nueve por el flujograma de selección. **Discusión:** Transmitir malas noticias es frecuente en las áreas de oncología y cuidados paliativos,

con fuerte influencia cultural en la autonomía del enfermero en ese proceso. **Conclusión:** El modo y la habilidad del enfermero durante la acción influenciarán la reacción del paciente sobre el mensaje. El tema es escaso en la literatura, necesitando ser explotado.
**Descriptores:** Revelación de la Verdad; Comunicación; Enfermería; Familia; Información.

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## INTRODUCTION

Bad news is defined as any information with unpleasant content related to the patient and transmitted to him or her by the caregiver or family that involves a drastic change in future perspectives and/or health prognosis[1]. The contents and context of bad news are usually associated with death, severe illness and oncological conditions[2].

The communication of bad news arises in situations that can negatively modify, whether partially or radically, the future lives of the people involved - patient, family and community. Consequently, the importance of quality in the process of communicating bad news is underscored; this includes all professionals in the multidisciplinary team, at all levels of care and complexity, who provide health services to the population[2].

The manner in which health professionals communicate bad news can generate strong emotional reactions in people who receive the news, such that they will never forget how the communication was made and by whom. Furthermore, depending on their perception of the experience they may never forgive the person for the way in which the bad news was given[3].

Verbal and non-verbal communication are both forms of message delivery and the ability to use them effectively in the breaking of bad news is an important skill to be developed by nurses[3].

The nurse is the professional who cares for the patient by providing 24-hour daily nursing care and planning and as such is in frequent and direct contact with family and caregivers. In addition, there is the role of coordinating the nursing team. This team comprises professionals from graduate and technical categories, differentiated by the level of knowledge and practical activities in the caring process of their work. The nurse has the legal responsibility to provide training and competence for the team they coordinate, with the objective of promoting quality, scientific evidence-based care and patient safety[2-3].

In this context, the present study aims to identify from the Brazilian and international nursing literature how the process of communicating bad news occurs in the multiple scenarios of nurses' practice.

Thus, this integrative review of literature has the purpose of describing how the communication of bad news is managed and the nurses' role in this process[4].

## OBJECTIVE

Describe how the process of communicating bad news is established and identify how nurses exercise this function.

## METHOD

An Integrative review is a valuable part of the process of creating and organizing the body of a literature review that provides construction and analysis, as well as a basis for discussion regarding the methods and results reported in the publications[5-6]. The search period was from 1993 to 2014, due to the scarcity of studies covering the theme of this review.

The English language keywords used in the search were: (Truth Disclosure OR Truth Disclosures) AND (Communication OR Personal Communication OR Misinformation OR Communications Personnel) AND (Nursing OR Nurses) AND (Family OR Families OR Family Members OR Family Member OR Relatives OR Extended Family OR Extended Families) AND (Palliative Care OR Palliative Treatment OR Palliative Treatments OR Palliative Therapy). The international databases were: PubMed (www.ncbi.nlm.nih.gov), Embase (www.embase.com), Scopus (www.scopus.com), Web of Science (http://apps.webofknowledge.com/UA_GeneralSearch_input.do?product=UA&search_mode=GeneralSearch&SID=1Eseu6Xbm37tvghsOGD&preferencesSaved) and CINAHL (access via Periódicos CAPES www.periodicos.capes.gov.br/).

The keywords used for the Portuguese search strategy were: (Revelação da Verdade) AND (Comunicação) AND (Enfermagem) AND (Família OR Membros da Família) AND (Unidades de Terapia Intensiva OR Centro de Terapia Intensiva OR Centros de Terapia Intensiva OR CTI OR Unidade de Terapia Intensiva OR UTI) in the Bireme database (www.bireme.br).

After the initial results from the searches in the national and international databases, the four steps of the article selection process flowchart (Figure 1) were performed. In the first step, the articles found were reviewed to eliminate duplicates. In the second step, two reviewers (researcher and advisor) checked the titles of the articles for availability and removed those that were not free of charge. In the third step, the two reviewers agreed to read 55 articles, including in English and exclude those that were in the form of the journal's editorial. In the fourth step, the texts were read in digital format and the inclusion criteria in terms of content were those referring to the care and role of the nurse in the breaking of bad news.

The articles included in the present study were analyzed according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) tool that constitutes a checklist of 32 items that comprise three domains: (i) research team and reflexivity, (ii) study design and (iii) data analysis and reporting[7].

The level of scientific evidence contained in the articles included in the study was identified according to the following criteria: level 1 - systematic reviews or meta-analysis of relevant clinical trials; level 2 - evidence from at least one well-delineated randomized controlled cohort; level 3 - well-delineated

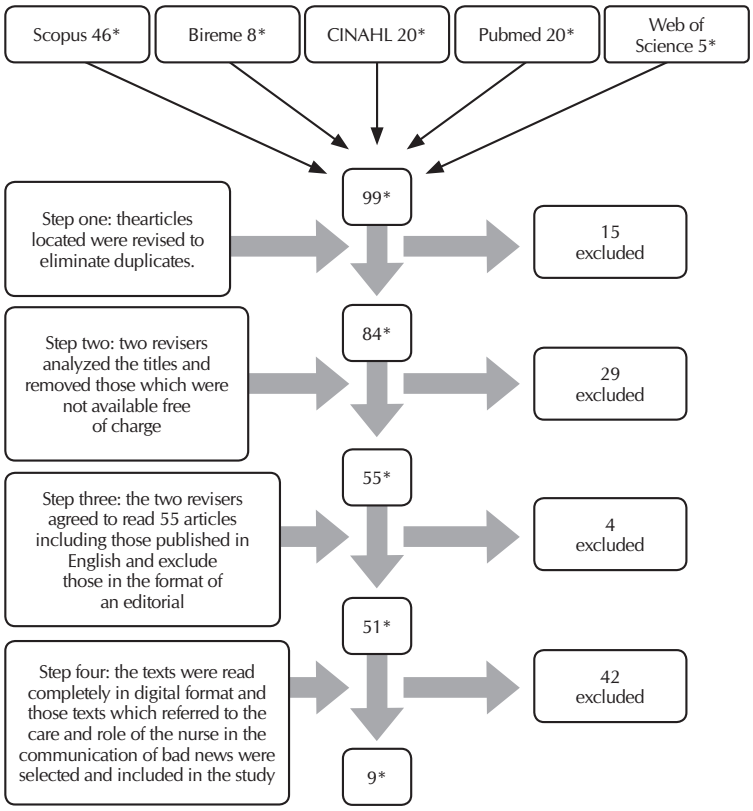
clinical trials without randomization; level 4 - well-delineated cohort and case-control studies; level 5 - systematic review of descriptive and qualitative studies; level 6 - evidence derived from a single descriptive or qualitative study; level 7 - opinion of authorities or expert committees including interpretations of non-research based information[8-9].

## RESULTS

A total of 99 articles were identified in the databases: Scopus (46), Bireme (8), Cinahl (20), Pubmed (20) and Web of Science (5). The process of including and excluding the articles and their analysis is shown in Figure 1, after applying this process nine articles remained and were included in the present review.

The nine articles included in the study were saved on a pen drive, read in full and individually described in electronic form. The relevant data were assessed according to the COREQ tool. Three of the nine articles selected for use in the present study were not submitted to COREQ because they were literature reviews.

Regarding use of the COREQ instrument in order to comprehend the aspects of each article included in this review, the highest score was obtained by the study carried out in Lebanon[10], by professors linked to the Nursing School of the Universidade Americana de Beirute, who had fulfilled the requirements in items related to: identification of the researchers and their relationships; methodological orientation; sampling; sample size; non-participation (refused/dropped out); setting of data collection; presence of non-participants; description of sample; interview guide; repeat interviews; audio/visual recording; field notes; duration; data saturation; transcripts returned; description of the coding tree; and derivation of themes—representing a total of 27 out of the 32-item checklist contained in the instrument.




*Note: *number of articles.*

**Figure 1** – Flow chart showing the four stages in the selection of articles identified in the national and international databases

Chart 1 presents the characteristics of all nine articles included in the study, considering: title, database, country of origin, methodological design, context, number of items attributed by the COREQ instrument and evidence level of the studies.

**Chart 1** – Characterization of the nine articles included in the study: title, year/country of origin, methodological design, context, items according to the Consolidated Criteria for Reporting Qualitative Research and level of scientific evidence, Botucatu, São Paulo, Brazil, 2015

| Title | Year/ country | Design | Interventions | Conclusions | COREQ*/ evidence level** |
|---|---|---|---|---|---|
| Decision-making in palliative care practice and the need for moral deliberation: a qualitative study. | 2004 Holland | Qualitative approach | Interviews | It is important to preserve the autonomy and decision making of the patients by offering correct information. | 24/VI |
| Percepções da família do recém-nascido hospitalizado sobre a comunicação de más notícias. | 2009 Brazil | Qualitative approach | Interviews | The contents of the message should be clear and detailed regarding health condition and treatment of the child, without ambiguity and wholly true, while offering support to face the news. | 22/VI |
| Review of communication and family caregiver content in nursing texts. | 1999 USA | Literature review | Database search | There is a great opportunity to improve the teaching of nursing regarding the "end-of-life". The publications on the theme require improvement. | Not applicable/V |

To be continued

Chart 1 (concluded)

| Title | Year/ country | Design | Interventions | Conclusions | COREQ*/ evidence level** |
|---|---|---|---|---|---|
| A phenomenological study of nurses' understanding of honesty in palliative care. | 2010 Sweden | Qualitative approach | Interviews | For palliative care it is necessary for the nurse to have ethical virtues and communicate with honesty. | 26/VI |
| Patterns and barriers in information disclosure between health care professionals and relatives with cancer patients in Greek society. | 2005 Greece | Literature review | Database search | Teaching institutions should stimulate studies into palliative care and the training of future care professionals regarding the theme. | Not applicable/V |
| Should palliative care patients' hope be truthful, helpful or valuable? An interpretative synthesis of literature describing healthcare professionals perspectives on hope of palliative care patients. | 2013 Holland | Literature review | Database search | Health care professionals should focus on balancing hope and truth. | Not applicable/V |
| Cancer patient expectations of and communication with oncologists and oncology nurses: the experience of an integrated oncology and palliative care service. | 2000 Israel | Qualitative approach | Interviews | There is a necessity for powerful and quality interpersonal communication skills among those providing care for cancer patients. | 19/VI |
| To tell or not to tell: attitudes of Chinese oncology nurses towards truth telling of cancer diagnosis. | 2007 China | Qualitative approach | Questionnaire | Nurses believe that the doctor is a health professional most suited to communicate the truth. | 25/VI |
| Lebanese cancer patients: Communication and truth-telling preferences. | 2008 Lebanon | Qualitative approach | Interviews | There is a need for truthful communication with the patients and their family members | 27/VI |

*Note: *Consolidated Criteria for Reporting Qualitative Research; maximum number of items = 32; **level of evidence I to VII.*

## DISCUSSION

The nurse is an active agent in the communication of information to the patient and family, such that communication skills are essential competencies to be acquired in the training of these health professionals.

In the present study, the main areas of practice among the nurses described by the authors were: four studies in the field of oncology; four in palliative care; and one in neonatology. These scenarios are characterized by their degree of complexity and present a tenuous boundary between treatment success and failure. Consequently, the nurses' ability to communicate news about the evolution of the patient condition becomes a factor vulnerable to misunderstandings and misinterpretations in the communication process and in the care itself.

Although the contents of bad news have a great impact, there are few findings on the role of nurses in this function, neither in the literature nor in publications dealing with chronic, debilitating disease or end-stage patients.

A review of the literature[11], elaborated by American professors, points out that the communication of bad news by nurses is a topic that needs to be better addressed during their academic training, since there are innumerable areas where this professional will need the skills and resources required to communicate unpleasant facts to patients and family members. The consideration of this subject must see significant improvements in the teaching of nursing.

In a Greek study[12], the authors report that nurses lack the necessary skills and/or are not encouraged to perform this task and are often not given permission to do so by the doctors. The latter, in turn, also do not receive adequate training in the schools of medicine regarding the communication of bad news. They also affirm that nurses are allowed to communicate only that which has been permitted. This panorama shows the nurses' lack of autonomy and submission in this context, often due to cultural issues and lack of empowerment. They conclude that it is the duty of medical schools to encourage studies into palliative care, as well as to train future medical professionals and nurses to ensure they have the skills required for communication of such news to their patients.

A Chinese article[13] corroborates the Greek article[12] regarding lack of autonomy of the nurse in the communication of bad news. The authors report that none of the nurses interviewed considered they were the appropriate professional to inform patients of the diagnosis. Most believed that the doctor should disclose this information. Nurses believed that cancer patients should be informed about the disease immediately after diagnosis and that a quiet, undisturbed location is most appropriate for this to take place.

One of the Dutch articles[14] describes the phenomenon of communication of bad news to patients in palliative care in five different hospital institutions: oncology sector of a general hospital; oncology sector of a university hospital; a hospice for palliative care; a home care service; and a general practice clinic.

The authors[15] underscore that nurses must work with reality, be honest and consistent in breaking bad news, while fostering the hope of the patient to continue treatment. However, they affirm that hope can be destroyed by the truth and disclosing of medical information and/or use of the term "palliative care".

A review of the Dutch literature[16] focused on the hope of palliative care patients from three perspectives: realistic perspective - hope as a true expectation and with health professionals focused on adjusting hope to the truth; functional perspective - hope as a coping mechanism that should help patients and practitioners focused on fostering hope; and narrative perspective - hope in the sense of being valuable to patients and health care professionals intent on interpreting it.

Doctors and nurses stated that hope was an expectation that must be true and that they want their patients to avoid futile treatments by helping them focus on what needs to be done before death.

Two Dutch articles reported that health professionals were focused on adjusting hope to the truth, such that the objectives of health professionals in communicating the news is focused on balancing hope with truth in order to foster hope in the sense of aggregating value to the interpretation of information; with a view to considerations of quality for patient, family and health team.

Honesty for these professionals is conceived as essential so that the patient can also be autonomous in their decision making, regarding whether to continue or not with their treatment.

It is understood that the nurse is autonomous and works in parallel with other health professionals when it comes to communicating bad news and is an indispensable care professional in the communication process involving patients and their family.

The importance of honesty is reinforced by a Swedish study[15] based on interviews with nurses working in palliative care. The authors suggested a theoretical conceptual model between honesty, truth and falsehood, because for palliative care it is necessary for the nurse to have ethical virtues and this virtue can be opposing and contrasting.

According to another study[15], nurses have reported that honesty is a prerequisite for quality care. Dishonesty will always be discovered eventually, arousing anger and distrust in the patient.

In addition to this expectation regarding honesty for nurses, it is also expected for all professionals within the health system and community. Many challenges can shake honesty for a variety of reasons, such as explaining the reality of treatment and relating to the team.

In a Brazilian article[17] the authors discuss the transmission of messages to parents of children in a neonatology unit. They focused on how the bad news was conveyed and on its content; from the perception of the family about the health professionals' approach for the transmission of news; and in the use of communication strategies by health professionals.

The families interviewed in a study[17] reported that the content of the message should be clear and detailed about the child's health and treatment condition, unambiguous and entirely true, while providing support to help with facing the news. They also affirmed that the family perceives the change of attitude in health professionals according to whether the news is good or bad. Furthermore, those health professionals with longer experience possess better abilities and facility for disclosing the news and to promote solidarity with the family. In this way the family feels emotional support; however in their perception there are positive and negative aspects in the contents and manner in which the doctor and nurse transmit bad news about their baby's health conditions[17].

Something very notable for patients and families at the time of reporting bad news was the professional's physical posture, they stated that they knew when the nurse had more professional experience, since the less experienced workers ended up denouncing the advent of bad or good news by their posture and expressions[17].

When receiving bad news, the family's emotional conditions together with the complex nature of the information can cause difficulties in comprehending the message, leading to non-acceptance or misunderstandings[17]. Thus, it is important that the professional responsible for the communication should validate the content of the messages to the families, in order to provide explanations whenever appropriate. This approach allows active participation by parents in the treatment of their children, as well as a better support for them to cope with the situation.

Similarly, patients in an article from Israel[18] stated that during the breaking of bad news by health professionals, they value eye-to-eye contact, an affective touch and that the information is given in a delicate and sensitive manner. Most received the bad news from doctors and preferred to share the news with their family and the health professional team, while withholding the information from friends and third parties.

In a study carried out with patients attended an oncology outpatient clinic[18], knowledge about the disease status and communication of news regarding treatment were evaluated. Some patients reported that the disease was in remission and/or in indeterminate status, however in reality it was in a progressive stage. They also cited a preference for receiving news from doctors.

It is noteworthy in the studies described[12-13] that the breaking of bad news was culturally presented as an activity attributed to the medical professional and preferably accepted by the patients.

Professors at the Universidade Americana de Beirute, School of Nursing in Lebanon concluded from a study[10] that there are central themes arising from the experience of Lebanese cancer patients receiving palliative care, such as negative feelings regarding the following aspects: feeling distressed about being dependent, disliking the sentiments of pity by other people, they were worried about their family, they felt dependent on God and divinity, dislike of hospitalization, not liking being unproductive, being afraid of pain and suffering, and the need to communicate. The latter was seen as a stress-relieving treatment. It is highlighted in this study that the social attitudes towards cancer and the norms in communication and the revelation of truth are deeply influenced by cultural beliefs and norms that can interfere in the communication process.

This integrative review has demonstrated qualitative content with a methodological approach to the reports of patients, family members, physicians and nurses about the need to evaluate the content and way such news is transmitted. In this process it is important to provide clarity and a detailed explanation in a manner that avoids using technical terms and jargon. The health professional must be honest and dose the revelation of truth with skill in order to maintain the patient's hope in their treatment. For this communication skill, it is essential that it has consistency of behavior and that academic preparation should be strengthened in all the cultures cited.

In the communication of bad news it was highlighted how influential the cultural question of the country or region is and how this influences the decisions of what and how it will be communicated to the patient. Examples are the articles described in Greece and China where nurses do not feel prepared for this work, preferring the doctor to do this or even affirming that it should be uniquely the doctors' responsibility.

Articles from Sweden, the Netherlands, the United States and Brazil have demonstrated a greater autonomy of nurses in communicating with patients, as well as the importance of the influence of the ambient where the bad news will be revealed. It is also emphasized that the patient's desire in palliative care is to know the status of his or her illness; likewise, oncology patients wish to be told the prognosis of the disease.

### Study limitations

The limitations of this study lie in identifying who is really responsible for communicating bad news: the nursing team, the doctor, or the social worker? Future studies of this nature, but in cultures and countries with a similar socioeconomic and religious context, may contribute to clarify and establish the diversity identified in this review.

### Contribution to nursing, health or public policy

The present integrative review contributed by verifying the most modern approaches in the communication of bad news, according to the world cultural diversity, and not only in relation to an activity limited to nursing. The study demonstrated the need for clarity in the language used by health professionals responsible for communication and that sometimes patients did not have a real understanding of their disease and condition. In addition, some patients stated that they did not want to know about their health situation, which indicates the importance of respect for autonomy regarding treatment and respect for ethical and sociocultural values.

## FINAL CONSIDERATIONS

This integrative literature review enabled us to learn the reality of breaking bad news in the cultural and professional context, showing the strong cultural influence on the work process of nurses in developed countries; where they have greater autonomy in discussing news with patients. However, it is notable that the cultural issue influences nurses, making them a submissive and non-autonomous professional in the communication of news to patients and their families. Sometimes this behavior becomes comfortable for the nurse, when compared to other health professionals.

Regarding the religious cultural aspect, the impact is characterized by the patient's desire to fully understand their diagnosis and/or prognosis and also to make decisions concerning their treatment.

It has become clear that breaking bad news is prevalent and frequently approached in the areas of oncology and palliative care, due to the complexity of the treatment and the close relationship with the terminal phase of life. Nurses have an active role in the transmission of messages in this context; their behavior and how the information is disclosed is relevant because it will influence the thought processes and how the patient will receive and assimilate this information.

Finally, despite the importance of communicating bad news, the subject is still little discussed in the literature. It is extremely relevant to encourage studies in the form of reports of experience, research and reviews so that scientific evidence can strengthen the practice of health professionals and promote quality care.

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