How best to communicate bad news over the telephone

Elizabeth Taylor

This article examines communication issues relating to breaking the news of a sudden and/or unexpected death to family members. It focuses particularly on the delivery of bad news over the telephone. Often it is the nurse who has to make the call. When dealing with unexpected death, nurses may be unsure what to say and resort to various euphemisms or anecdotal practices without full understanding of their implications. Current literature and guidelines will be reviewed in order to inform nurses regarding best practice techniques for communicating with relatives facing unexpected death. The importance of planning for sudden death through building relationships with patients and their families will be discussed. Particular focus is placed on communication skills and the relevance for nurses of training in this area. The ethical dilemma regarding what to say and when will also be explored. Practical suggestions will be included to illustrate points and encourage discussion among colleagues. *Conflict of interests: none*

KEY WORDS

Breaking bad news
Communication skills
Sudden death
Telephone communication

The media provides us with daily images of brutal and gruesome, or highly romanticised deathbed scenes. Professional literature regarding death and its management also tends towards polarised views. For example, palliative care portrays a planned, expected, 'good' death, whereas critical care is associated with the trauma of lives cut short in a dramatic fashion. The reality, for the majority of people, does not match either of these portrayals (Higginson, 2003).

This article examines the role of the nurse in communicating with families in a hospital or community setting when a patient has died suddenly. It is crucial for nurses to understand that the way in which bad news is given will always be remembered by the bereaved, whether delivered well or not (McCulloch, 2004). Complaints frequently focus on inadequacies in communication (Fellowes et al, 2004), while evidence suggests that communication skills can be enhanced with training (Wilkinson et al, 2002; Fellowes et al, 2004).

The literature and principles of breaking bad news (BBN) are considered in relation to sudden death. Particular attention is given to the role of the person breaking the news, the nature of the care provided at this point and its potential impact on the grieving process. Communication skills with regard to BBN over the telephone will be considered. Practical suggestions will be presented to encourage discussion among colleagues and promote enhanced levels of care at this difficult and crucial time.

What is a sudden death?

Given that the majority of people in the UK die from chronic illness (Seale, 2000), it is worth considering whether all 'sudden deaths' really should be unexpected. It may be helpful for the multidisciplinary team to decide on reflection whether the death was unexpected because the possibility was not discussed with the family, or whether it was genuinely unexpected.

While a death may not be imminent, if a person is frail, has a long-term degenerative condition, or is recovering from a previous significant health event or procedure, health care professionals (HCPs) should be aware that the person may deteriorate rapidly, or die suddenly. This potential deterioration must be included in the planning and discussion of care.

Breaking bad news

Being the bearer or recipient of bad news is difficult. Cooley (2005) notes that: 'Breaking bad news has had more comment and written word than any other patient/professional encounter and is still considered by health professionals to be the most difficult scenario.' The majority of HCPs would agree with Buckman (1992) that having to break the news of someone's death (and particularly an unexpected death)

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is one of the most stressful situations they face. When bad news is given by telephone the recipient may not fully understand what has been said and be unsure what is expected of them. The worries of HCPs include: not speaking to the right person; fear that the recipient of the bad news will collapse; being asked outright if the patient has died and, if that occurs, being unsure how to respond (Wright, 1996).

Available evidence

Nurses have a responsibility to 'base their care on current evidence, best practice and, where applicable, validated research' (Nursing and Midwifery Council (NMC), 2004). There is scant evidence in the literature over the last 10 years relating to BBN in the context of the case scenario (see box). Two literature reviews on communicating/breaking bad news were identified through a literature search of the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Medline (1996–2006).

The first (Ptacek and Eberhardt, 1996) highlighted the limitations of the literature on this subject and the lack of empirical evidence or justification, particularly with regard to what does and does not work. Fallowfield and Jenkins (2004) focused on the impact of BBN on doctors and patients in three specific settings: obstetrics/paediatrics, acute trauma and oncology. Both reviews pertain to communication with/from doctors but much of what is identified may be easily transferred to nursing practice. Fallowfield and Jenkins (2004) highlighted key areas of good practice throughout their review as identified by the recipients (*Table 1*).

Ptacek and Eberhardt (1996) recognised two distinct aspects of BBN: the setting and the message. They note that 'the patients' perception of the physician is less positive if the physician appears anxious, depressed, irritated or pressured'. They also identified that a warning shot is 'an effective way of reducing the element of shock' (see section on 'warning shots').

Edlich and Kubler-Ross (1992), Buckman (1992) and Kaye (1996) have all published guidelines regarding BBN. There are similarities between all three, in that all of the guidelines are based around four key principles (*Table 2*). While there is little empirical evidence to support the use of guidelines (Fallowfield and Jenkins, 2004), it is recognised that guidelines helpfully provide 'a backcloth against which bad news can be delivered consistently and sensitively' (Read, 2002).

The principles of breaking bad news

Buckman's (1992) six-step protocol (*Table 3*) is particularly helpful and informs much of the following discussion. He suggests that there are two strands to effective communication when BBN. The first focuses on imparting the information and the second on working with the subsequent emotions. He considers the six steps a necessary part of a BBN interview, although the second and third point are not used when informing of a death. The reader is recommended to consider this work for further clarification. The application of the four key principles of BBN (see *Table 2*) with reference to unexpected death will now be considered.

Preparation

In the context of sudden death, preparation may appear contradictory. The opposite, however, is true. Planning for an unexpected death begins as soon as the HCP and patient meet for the

Case scenario

Mary Smith, a 78-year-old woman, has been admitted to a medical assessment ward following a fall. She is very frail and has a severe chest infection. She lives with her elderly husband. Mr Smith was brought to visit his wife by a neighbour who keeps an eye on them both. They receive daily care from social services and a district nurse visits regularly. Their daughter lives a considerable distance away but she has contacted the ward staff and and plans to visit at the weekend. When Mr Smith came to see his wife the nurse found it difficult to gain information from him as he is very hard of hearing. His details are documented in the next of kin section of his notes along with his daughter's number. While Mrs Smith is being helped out of bed she collapses and has a cardiac arrest. Resuscitation fails and the nurse needs to inform the family. Whom should she contact and what should she say?

Table 1

What recipients of bad news want from health professionals

Understanding what is important to patients when sad or upsetting news is given
Informants who show some concern and distress at the news rather than cold professional detachment
Doctors who are confident, show concern and are caring but who also allow them plenty of time to talk and ask questions
Importance is attributed to the attitude and knowledge of the news bearer, clarity of message and privacy when receiving news

Source: Fallowfield and Jenkins (2004)

Table 2

The four principles for breaking bad news

Preparation
Communicating the news
Managing emotions
Planning the next step
Source: Edlich and Kubler-Ross (1992), Buckman (1992), Kaye (1996)

first time. When taking details from a patient of their next of kin the HCP needs to ask about the relationship, identify an opportunity to meet or speak to the next of kin, and ask if the patient has concerns about that person while in hospital. In the event of a patient's death, the relative becomes the patient (Buckman, 1992) and their care must be the HCP's utmost concern at that point.

The way bad news is given and subsequent actions taken may influence the bereavement process (Wright, 1996). It is vital to give time, thought and attention to the manner in which the news is to be given, rather than seeing it as something to be done as quickly as possible. There is no clear evidence (or guidelines) regarding who should deliver this news. The literature does show that people prefer to hear bad news from professionals who know them and the patient (Fallowfield and Jenkins, 2004). The person who fulfils that criterion may be the one best placed to give the news, regardless of professional background, providing that he/she is competent (NMC, 2004).

Deciding what to tell

Whether the family should be informed by telephone of the death of their loved one is unclear. Clearly it is not the best medium to use when BBN, primarily because of the lack of immediate available support for the relative (Kendrick, 1997); however, at times, it cannot be avoided. Knowledge of the patient and family should enable a more informed decision about how to break the news. Best practice guidance (Department of Health, 2005) identifies that the most usual method, if the identified next of kin is not present at the death, is by telephone.

In relation to accident and emergency departments (A&E), Leash (1996), Wright (1996) and Kendrick (1997) advocate informing relatives that an accident or sudden illness has occurred and requesting attendance at the hospital. Kendrick (1997) advises that in this situation lying can be ethically justified, as the intention is to prevent harm and maximise benefit

Table 3

Six-step protocol for breaking bad news

1. Getting the physical context right
2. Finding out how much the patient knows already
3. Finding out how much the patient wants to know
4. Sharing information (aligning and educating)
5. Responding to the patient's feelings
6. Planning and follow through

Source: Buckman (1992)

by imparting the news in a supportive environment. However, caution must be exercised when considering the relevance of practice in A&E and transferring this to an environment where patients and their families are known to staff.

As trustworthiness is vital in the HCP/patient relationship (NMC, 2004), Buckman (1992) advises that it is crucial not to imply or state that the patient is alive at the time of the call if they are not. This untruth may cause a damaging breakdown of trust when the time of death is seen on the death certificate (Buckman, 1992) and could cause suspicion of there being something to hide. Buckman (1992) recommends that a direct question such as 'has the patient died?' must be answered honestly when asked at whatever point during the process of BBN. This could be softened with 'do you really want to talk about this on the telephone?' if a face-to-face conversation is the preferred option (Leash, 1996).

Travel times and the likely response of the family when arriving to find that the patient had died before they embarked need to be considered. It is recommended that those with a significant distance to travel (even to A&E), i.e. longer than an hour (Leash, 1996), need to be informed directly to prevent relatives rushing to be with their loved one.

If, for whatever reason, the nurse making the call believes it is inappropriate to give the news of the death over the telephone they should discuss this decision with colleagues and document in the notes why it was made (NMC, 2004). It may be, for example, considered inappropriate to give the news of a sudden death over the telephone to individuals with communication difficulties (speech, hearing or language). People recognised as being vulnerable because of mental health problems or specific physical needs may receive the news better face to face, as may those who are known to have reacted severely to a previous bereavement. Each situation needs to be dealt with on an individual basis which is only possible by getting to know the families. Forward planning will help HCPs to identify vulnerable people and plan accordingly. Best practice guidance (Department of Health, 2005) advises that:

- Every NHS trust should develop written protocols for death and bereavement in every department
- Death and bereavement issues should become a key element in all shift handovers and briefings
- A lead person for death and bereavement should be made available for every team or shift.

Implementation of these guidelines will assist with preparing for a sudden death. If the telephone is thought inappropriate then other options should be considered, e.g. a community nurse who knows the family could be

contacted. Alternatively, if the death occurs in a community setting and the family is local enough to be visited, it may be appropriate to give the news face to face (O'Donovan, 1999).

There is a clear lack of evidence to guide the HCP. The author's personal view is that the news of a death should be delivered directly, as soon as possible, to the most appropriate person. In the case scenario at the start of the article, a direct conversation with the daughter would appear to be the most appropriate choice. She will still have to speak to her father, which will be difficult because of his hearing problems. Therefore, being able to suggest other options such as giving her the numbers of the neighbour or district nurse, would be helpful (see below). If there are no other contact details and no community professionals available it could be more appropriate to contact the neighbour and ask her to bring Mr Smith directly to the hospital where the news can be given face to face. Whether to tell the neighbour directly, if asked, will depend on knowledge of her relationship with Mr and Mrs Smith and information gained from the patient before she died. Anticipating this question and discussing with colleagues would be invaluable.

Who to tell

'Next of kin' is a misunderstood term. It is often thought to relate to blood relatives although it is not defined by law (Webber, 2004). Some people may confuse next of kin with the intestacy distribution list, enforced if there is no will (Department for Work and Pensions, 2006). As families have become more diverse the practice in most NHS trusts is to ask patients to nominate their next of kin (Webber, 2004). This can be best explained by asking the patient whom they would like the hospital to liaise with regarding decisions on their care or to contact in an emergency situation. If the named person is thought to be someone who may not cope well with this situation, details of a second person should be taken as first contact The Royal College of Nursing and Unison (2004) have produced guidelines regarding seeking clarification of next of kin.

Communicating the news

Whether the intention is to tell or not, the HCP needs to be prepared for a potentially long, emotionally taxing call, with possible subsequent calls. The call needs to be made in private, with no possibility of interruption from bleeps, colleagues, patients or relatives.

Warning shots

When the news of a sudden death is to be given it needs to be delivered as clearly as possible. This forms the fourth step (sharing information) in Buckman's (1992) six-step protocol (see *Table 3*). A warning shot is a comment used to alert the recipient to the seriousness of what is about to be said. It would, for example, be inappropriate to start with 'I'm just ringing to let you know…' or 'Thanks for coming in'. The gravity of the situation needs to be communicated from the start to help the recipient prepare for the news that is to come. The timing of the call itself (see below), the tone of voice used and the lack of social niceties will help alert the recipient that he/she is about to hear something important.

Telephone communication

At the start of the call it is important to state who you are, where you are calling from, clarify the identity of the person contacted and whether you have met/spoken to that person previously and, if so, when (Buckman, 1992). When calling a mobile phone, check if it is appropriate to give the news. If not, for example, as a result of driving/location/in a meeting, suggest the person moves to a safe, private place and agree a time to call back. Clarify if the person is alone or has someone else with him/her. If there is a sudden end to the conversation, knowing whether the person is alone or not will help inform if you need to contact the emergency services.

When feeling anxious people tend to speak faster than normal. Therefore, nurses should intentionally slow their speech, enabling the recipient to register the importance of the conversation and hear clearly what is being said (Buckman, 1992). As the telephone removes all opportunities for non-verbal contact/support, nurses must listen intently and respond appropriately with an empathic tone of voice (Pettinari and Jessop, 2001).

Breaking the news

Begin by acknowledging the difficulty of having the conversation on the telephone as this will reduce its negative impact and serve as a warning shot, along with the checks made and the timing (Buckman, 1992). It may be helpful to acknowledge the last contact made with the patient before stating formally that you are about to deliver bad news, e.g. 'I know you spoke to your wife just a couple of hours ago but I'm sorry to say that I have some bad news about her' (Buckman, 1992).

If asked if the person has died, answer directly. It is important that the word 'died' is used even if the recipient uses other euphemisms such as 'passed away', to prevent misunderstandings (Wright, 1996). If not asked, a brief simple narrative description is helpful to build up to what has happened, e.g. 'She awoke with sudden chest pain, we contacted the doctor, her heart stopped beating, we tried to resuscitate her for some time but were not successful, I'm sorry to tell you that she has died' (Buckman, 1992).

Managing emotions

Acknowledging emotion

According to Buckman (2000): 'The central principle of effective therapeutic dialogue is that the patient should perceive that his/her emotions have been heard by the professional and acknowledged.' The most likely response to bad news is shock and this may be expressed in a variety of ways, including denial, anger, bargaining, tears or acceptance (O'Donovan, 1999). Sanders (1996) suggested that the HCP should adopt an attitude of 'non-judgmental warmth' which requires the absence of judgment and the communication of warmth.

The first step in responding is to listen effectively. The HCP needs to distinguish their own emotions (dealing with the death, making the call, expected response) from those

of the person being contacted. This enables the HCP to hear what is actually being said and to recognise the emotion behind it. This connection is communicated back in the response (empathy) (Buckman, 2000). Examples of responses are as follows:

- If the person on other end of the telephone is crying or shouting in response to the news, a statement such as 'I recognise that it is very distressing for you to hear this news, particularly by telephone'.
- A response to a person who repeatedly says 'it's not true, it can't be' could be 'I appreciate it is very difficult for you to take this in, especially as he seemed to be making such progress'.
- To someone who goes very quiet or says 'thank you for letting me know' a response such as 'It seems like this news has stunned you. Would you like me to help you think about what you want to do next?' might help.

The above statements are examples only. It is important that HCPs use words with which they feel comfortable and which are in direct response to what is heard. The reason for acknowledging the emotion in this way is to give it legitimacy and to demonstrate support. If strong emotions are not acknowledged the HCP will appear 'insensitive and this will render further interaction useless' (Buckman, 2000). If the person is tearful, and particularly if they are alone, offer to stay on the line for a while but do not try to keep them talking if they are keen to go. Always agree what will happen next before hanging up.

Silence

Silence on the telephone can be difficult to manage, especially after breaking such devastating news. It also appears much longer on the telephone and the use of sounds and words, e.g. 'uh-huh', 'mmm', 'take your time — I'm still here' should replace a slight touch or eye contact (Sanders, 1996). Reflecting back can help to break the silence (Buckman, 1992), e.g. 'it seems that this is overwhelming for you'. If there is concern for the person's health, e.g. prolonged silence, no response when you talk to the recipient and shortness of breath, contact the emergency services and ask for an ambulance to attend. The person will need to be informed of your plan and their response will help you to ascertain if this is appropriate.

Communication skills training

It is not surprising that HCPs are reluctant to enter into such emotionally challenging conversations. In addition, evidence suggests that communication skills do not necessarily improve with experience alone but can improve with training (Fellowes et al, 2004). The National Institute for Health and Clinical Excellence (NICE, 2004) recommends that those who communicate particularly distressing news should have enhanced communication skills or be supported by someone who has those skills, although all staff should be able to respond appropriately in the first instance. Two government papers (NICE, 2004; Department of Health, 2005) recommend that all HCPs should have access to training and learning opportunities which focus on communicating with, and supporting, families at this time.

Planning the next step

This is a crucial part of any BBN interview. It helps to give people receiving the news some focus and control of a situation that is overwhelming them (Wright, 1996). It is the responsibility of the person making the call to help the recipient make plans for the next few minutes and hours. For example, offering to contact another relative on their behalf can be helpful, but be prepared to be patient while the person finds a telephone number, reassuring them that any confusion they are feeling is normal (Wright, 1996). Having other numbers in the notes already is very useful at this point.

There are two possible options the relative may wish to consider: visiting the ward directly with the option of being involved in last offices; or taking some time to consider the situation and waiting for other family members and travelling in together later. In the latter case, inform the person that the ward staff will perform last offices and the family may need to view the body in the mortuary. In the community, the family will need to liaise with a funeral director about arrangements. Some religious customs may dictate the course of action that will be taken (Neuberger, 2004) but discussion of these is outside the remit of this article.

If the family plans to visit, give the name of the person who will meet them, ideally the one making the call and ensure that someone is ready to greet them as they arrive. An accurate, detailed record of the time of the call(s), what was said to whom and the plans made are important, as some relatives may wish to clarify certain issues (Wright, 1996).

Beginning to grieve

According to Wright (1996): 'The bereaved person will never again have the chance to work through this most difficult time; they must be given the space and time to in the immediate term. It is an opportunity to begin the normal process of grieving and should not be lost.'

Empirical evidence on the impact of the news of sudden loss is inconsistent. It may be influenced by personality and the nature of the relationship between bearer and recipient (Stroebe and Schut, 2001). Worden (1991) has identified seven special features of a sudden death (*Table 4*). These are emotions and experiences that will take considerable time to address. However, there are some interventions that can have a positive effect on the immediate grieving process and lay the foundation for future work. These are discussed below:

- *A sense of unreality about the loss:* help the survivor to actualise the loss by facilitating viewing the body as soon as possible. The words 'died' or 'dead' should be used.
- *Exacerbations of guilt feelings:* allow expression of these feelings (e.g. 'if only' statements) and

help the family to test them out by considering together what difference their actions may have made. Offering and enabling the person to spend some time alone with the deceased to say anything they would like to have said can be particularly helpful.

- *The need to blame:* the 'desire for retribution may be a defence against the reality and pain of the loss' (Worden, 1991). The HCP may need to be prepared to 'absorb rather than deflect the anger' (O'Donovan, 1999) by expressing sorrow for their loss, offering to clarify what happened or reiterating that everything possible was done (O'Donovan, 1999). It is important not to become defensive.
- *Involvement of medical and legal authorities:* for example, a post-mortem may be required or the family may wish to make a complaint. Accurate documentation of all that has occurred will help. Be prepared to provide information on the processes involved.
- *An increased sense of helplessness:* nurses can take an advocacy role, for example, by helping the family to take some control over what they want to do, working to keep the body on the ward until the family arrives, or guiding the family regarding what is allowed by stating 'feel free to touch him', 'talk to him', or 'take as long as you want' (Wright, 1996).
- *Unfinished business:* the opportunity to spend some time with the deceased soon after the death may help with any immediate issues such as saying sorry.
- *An increased need to understand:* be prepared to repeat what has occurred as often as required. Leave the option open of a subsequent visit to the ward or meeting with the consultant to clarify what actually happened (Wright, 1996).

A final responsibility after the provision of support, completion of formal documentation and the return of the patient's property, is to assist the relatives to leave the hospital. It is essential to acknowledge the emotional difficulty of leaving, as well as attending to more practical matters such as arranging transport (Wright, 1996). Information should be provided regarding what to do next, local bereavement support services and a reminder of other potential sources of support, e.g. the GP and community nurse (who must be informed of the death as soon as possible).

Looking after each other

Providing support to families after sudden death is time consuming and emotionally demanding. Managers need to be aware of the impact this can have on individuals (Read, 2002). It is important that the staff involved have the opportunity to reflect on what has happened in order to support each other. Support can come in a variety of formats, both formal and informal (Read, 2002). It is important that each individual staff member is able to identify a source of support with which they feel comfortable and senior staff must take responsibility for ensuring that this occurs (Parkes, 1999).

Conclusions

This article has considered four key stages for delivering the news of a sudden death. Of particular importance is pre-emptive planning for such an event, even when death is not expected. Communicating such news is difficult but the skills can be learnt and training is recommended (NICE, 2004; Department of Health, 2005). Guidance is available regarding best practice on caring for families after the death of a patient (Department of Health, 2005). This document provides standards against which units can assess their own practice in this area. Ward managers may wish to consider this guidance with the aim of making death and bereavement key elements in all shift handovers and briefings. They could also promote working with senior colleagues across the care environment to identify a lead person for death and bereavement available for every team or shift. A useful tool for developing and implementing new ways of practice has been published by the NHS Modernisation Agency (2005).

Table 4

Special features of a sudden death

A sense of unreality about the loss
Exacerbations of guilt feelings
The need to blame
Involvement of medical and legal authorities
An increased sense of helplessness
Unfinished business
An increased need to understand

Source: Worden (1991)

The purpose of this article has been to highlight to nurses the importance that needs to be attributed to working with families at such a difficult time. It has also demonstrated the potential impact that nurses and other HCPs can make at the start of a bereavement journey. Quite simple acts such as giving permission to hold the hand of the deceased, through to the more complex communication skills, or advocating on families' behalf, have been explored. The challenge is for nurses to utilise the opportunities they have to improve the unique experience of individuals at this distressing time.

Recommendations for practice

- There is a need for more empirical research on the impact on the HCP of informing relatives of both expected and unexpected deaths and the skills required for both. It would also be beneficial to gauge the views and experiences of family members on receiving such news.
- Nurses should explore with colleagues their responses to the discussion above. Such a discussion should provide a starting point for deciding how to inform families of sudden death, or how the care environment can facilitate the grieving process following an unexpected death.

- Nurses should be given the opportunity to listen to colleagues making such calls. When undertaking calls objective feedback on the skills used and the strengths and weaknesses of the call should be provided.
- Nurses should also be given the opportunity to talk about the topic in a staff meeting so that feelings and thoughts can be raised at a time when staff have more time to consider and reflect. EOLC

Useful resources

Breaking Bad News Web Site
www.breakingbadnews.co.uk

Department for Work and Pensions: 'What to do after a death in England and Wales' http://www.dwp.gov.uk/publications/dwp/2006/d49_april06.pdf

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Key Points

- Relatives will always remember the way in which the news of the death of a loved one was broken to them. The way the news was given and subsequent actions may influence the bereavement process.
- Breaking news of a patient's death to a family member causes a great deal of anxiety among nurses and other health professionals, particularly when the death was unexpected.
- The four key principles of breaking bad news are: preparation; communicating the news; managing emotions; and planning the next step.
- People prefer to hear bad news from professionals who know them and the patient.
- The telephone is not the best medium for breaking bad news but at times it is unavoidable.
- There is no consensus in the literature with regard to whether to tell relatives the truth over the telephone when a patient has died unexpectedly. However, trust is a vital component of the nurse/patient relationship and an untruth may cause that trust to break down.