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Understanding the Skills Necessary for Advanced Practice Nurses in Oncology to Deliver Bad News to Patients with Cancer: The Results of a Delphi Analysis

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ABSTRACT

PROJECT TITLE: UNDERSTANDING THE SKILLS NECESSARY FOR ADVANCED PRACTICE NURSES IN ONCOLOGY TO DELIVER BAD NEWS TO PATIENTS WITH CANCER: THE RESULTS OF A DELPHI ANALYSIS

Overcoming the dichotomy of providing bad news in a compassionate, empathetic manner that strengthens dialogue and enhances a caring environment is the ultimate challenge advanced practice nurses (APN) face in oncology. This study aims to understand the skills necessary for APNs in oncology to deliver bad news to patients with cancer.

Using a Delphi analysis, an established method of developing a consensus, a novel, patient-centered survey tool has been developed designed to extract as much information as possible about the present issue from an expert panel. Oncology APNs were recruited via Facebook. The survey tool was administered using a web-based survey tool. Content analysis was applied to the stories and responses to open-ended questions that panelists submitted. Results were collected and then presented back to the panel for ranking.

Twelve expert panelists reached a consensus on a practice-based method focused on teaching empathy and self-awareness. The results of this pilot project serve as the foundation for future research and for the development of a curriculum to educate new APNs or those new to the field of oncology.

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UNDERSTANDING THE SKILLS NECESSARY FOR ADVANCED

PRACTICE NURSES IN ONCOLOGY TO DELIVER BAD NEWS TO

PATIENTS WITH CANCER: THE RESULTS OF A DELPHI ANALYSIS

by

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We, the undersigned, certify that the project of the following student
meets the required standards of scholarship, format, and style of the
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CHAPTER 1: INTRODUCTION

Florence Nightingale reminds us that a core element of care is to provide comfort to patients at their time of need and to be receptive to all their needs (Kolcaba & Kolcaba, 1991). Part of creating this comfortable environment is to provide accurate information, even when the news regarding the patient's care is not good (Stovall, 2016). Patients and their families expect news to be delivered with empathy and compassion, with each individual patient expressing a different demand for control over their situation (Volker, 2004). Thus, considerations of control, empathy, and the demand for information in a comforting environment outlines the role of an advanced practice nurse (APN) in oncology. We all want to deliver the truth along with options in a manner that instills hope and assures that patients and their family go home feeling comfortable and in control. Most patients want a full disclosure of information (Eid, Petty, Hutchins, & Thompson, 2009). Failure to establish good communication with patients can thus have significant consequences, including poor compliance, increased anxiety, and increased malpractice claims (Eid et al., 2009). Overcoming the dichotomy of providing bad news in a compassionate, empathetic manner that strengthens dialogue and enhances a caring environment is the ultimate challenge APNs in oncology face.

APNs are common members of medical oncology teams at large academic medical centers and smaller, community-based practices. While the exact number of APNs in medical oncology is difficult to determine, a 2014 survey by the American Society of Clinical Oncology (ASCO) identified over 2,700 APNs in practice (ASCO, 2015); the consensus from this report was that there is "widespread employment" (ASCO 2015, p.10) of APNs. Of note, there were 1,800

physician assistants (PA) identified as working in US oncology practices (ASCO, 2015). Possibly due to the complexity of care required for patients with advanced cancer or the significant psychosocial burden this patient population endures, APNs plays an important role on an oncology team. They enhance the comprehensiveness of cancer care, applying an advanced level of holistic nursing care. However, there exist several challenges faced by new APNs or those transitioning into oncology.

Advanced practice nursing in oncology requires a unique combination of providing healthcare services in a caring, compassionate manner. While we should be aware of the latest pharmacologic developments to treat cancer, we must also be cognizant of the psychosocial needs of our patients and their families. The balance between the incorporation of technical medical skills and creating a caring, compassionate, and therapeutic relationship can vary from one visit to the next. Patients often describe the cancer journey as a "roller-coaster" ride. As APNs, we accompany patients on this roller-coaster; this challenging role requires both physical and mental fortitude. This constant up-and-down emotional environment can be even more challenging when bad news is involved. Understanding how APNs learn to survive and thrive in this environment is thus the underlying question that led to this doctoral inquiry.

Theoretical Basis for Inquiry

In considering how APNs in oncology deliver bad news, there exist several theories or theoretical frameworks for possible use. At the highest level, creating a caring environment enabling the APN to deliver bad news with both empathy and compassion could be aligned with a grand nursing theory, such as Nightingale's environmental theory (Hegge, 2013). In many ways, having this skill is as

important as ensuring that the patient's room is clean. A grand environmental theory lacks practical connection to clinical dilemmas that APNs face in their practice (Kolcaba, 2001). Midrange theories are often developed from grand nursing theories; these may be a more useful guide in clinical practice for APNs (Ryan, 2009). The midrange theories demonstrate that theories are more adaptable and can be helpful to understand various current nursing science challenges (Kolcaba, 2001). One such theory plausibly used to understand the delivery of bad news to patients with advanced cancer is Katherine Kolcaba's comfort theory.

This theory states that "in stressful health care situations, unmet needs for comfort are met by nurses" (Kolcaba, 2001, p.86). The impact of enhanced comfort improves the patient experience and contributes to both patients and their families accepting health-seeking behaviors (Kolcaba, 2001). Moreover, Kolcaba notes the value that comfort has on the morals, recruitment, and retention of nurses (Kolcaba, Tilton, & Drouin, 2006). These are two important points when considering cancer patients and oncology nurses.

Kolcaba's comfort theory explains that comfort can come in three forms: relief, ease, and transcendence (Krinsky, Murillo, & Johnson, 2014). Conceptually, this implies that patients are comfortable when their individual needs are met—they are calm and able to confront challenges (Krinsky et al., 2014). In exploring this theory, as a guide to a research project aimed at understanding the skills required to deliver bad news to patients with advanced cancer, there are several structural components to be discussed. These include the philosophical orientation, a definition of the word "comfort," and a consideration of a possible "fit" of this theory to the clinical dilemma.

Kolcaba (2001) has oriented the theory of comfort as per where patients are at the time of the interaction and what they need to advance or move beyond their

current state. "Because the theory is based on needs of patients, it is a representation of what patients hope to receive from nurses who are assigned to their care" (Kolcaba, 2001, p.86). Kolcaba (2001) goes on to explain that there are two primary needs that humans have and that they are unaware of. First is comfort. "(Comfort) needs provide a motivational drive that directs human behavior" (Kolcaba, 2001, p.86). When these (comfort) needs are met, patients feel and do better, since this relates to their health (Kolcaba, 2001). Second, is appreciating the influence of social and cultural demands, based on what society and culture have defined good nursing care must include (Kolcaba, 2001). Additionally, mutual benefit to both the nurse providing comfort and the patient receiving comfort is suggested (Kolcaba, 2001). Improved outcomes, timely discharges, and improved financial performance of the organization are also cited (Kolcaba, 2001).

Moreover, the comfort theory addresses the concept of whole person holism. "This perspective holds that persons are in and surrounded by their environment" (Kolcaba, 2001, p.87). Kolcaba (2001) highlights that both patients and nurses possess an energy field; the points at which these two fields interact is where the therapeutic relationship occurs. It is at this intersection where comfort, a decidedly simple yet complex element of nursing care, is created. Furthermore, the inclusion of the concept of whole person holism creates a strong link to grand nursing theories such as Nightingale's or Henderson's, in that we must consider more than just the germ or toxin and look at the patient and every element of their surroundings in their time of need.

"Comfort" has multiple meanings, but only one that has been discussed among nursing theorists since the time of Nightingale (Kolcaba & Kolcaba, 1991). In their work *An Analysis of Comfort*, Kolcaba and Kolcaba (1991) went to great lengths to define and understand the semantics of this word. They addressed the

history of comfort in nursing and the use of "comfort" in current nursing practice. From a historical standpoint, they reported that "comfort" as a concept is "positive, it entails feeling good and, in some cases, indicates an improvement from a previous state or condition" (Kolcaba & Kolcaba, 1991, p.1303). Furthermore, nursing theorists in the 20th century including Orlando, Watson, and Paterson and Zderad have used the concept of comfort in their theories (Kolcaba & Kolcaba, 1991). In present day nursing practice, comfort is an important element in several nursing diagnoses (Kolcaba & Kolcaba, 1991).

As is aforementioned, comfort can come in three forms: relief, ease, and transcendence (Krinsky, Murillo, & Johnson, 2014). Kolcaba utilized Murray's theory of human stress to deduce the concept of comfort and subsequently develop her nursing theory (Kolcaba, 2001). Through this process, she identified three grand nursing theories through which she deduced these three forms of comfort (Kolcaba, 2001). Orlando's work regarding nurses relieving the needs of patients led to "relief" (Kolcaba, 2001). Virginia Henderson's work on the 13 basic functions led to the concept of "ease" (Kolcaba, 2001). "Transcendence" was derived from Paterson and Zderad who wrote about patients being able to overcome challenges with the assistance of nursing (Kolcaba, 2001). Furthermore, Krinsky et al. (2014) describe Kolcaba's four contextual formats in which comfort can be experienced by patients. They include the physical, psychospiritual, environmental, and sociocultural (Krinsky et al., 2014). These four contextual formats best link the comfort theory to the doctoral inquiry in question.

Physical, psychospiritual, environmental, and sociocultural elements should be considered when thinking about the delivery of bad news to patients with advanced cancer. This is a patient-focused approach to understanding the

challenges of delivering bad news and it encompasses the patient's life, their tumor(s) and related morbidity, and the extent of the bad news.

Delivering bad news to patients can result in an immediate physical effect, i.e. fainting, nausea, or extreme sadness. The APN thus needs to be prepared for such responses and be trained to understand how to relieve the pain. The use of "pain" here is meant to encompass the impact of emotional distress and possible physical pain a patient might be experiencing from their cancer. This is one of the ways in which Kolcaba defines comfort—relief from pain (Kolcaba & Kolcaba, 1991). Moreover, a lack of physical response should be interpreted and handled appropriately. For example, it is important that the APN clarify that patient understands the context of the news if there is absolutely no evidence of a physical response. A despondent patient is also concerning and warrants additional care.

Furthermore, a patient's psychospiritual context has a role to play in determining how they will receive and process bad news. The manner in which patients view death and the extent to which their beliefs guide their fear of death are required to be considered by APNs when delivering bad news. From a whole person holism perspective, there may be other more significant fears than physically dying, which need to be addressed and could influence how bad news is delivered to a patient. For example, a most common question when facing mortality (especially among younger patients) is "who is going to care for my children?" "Care" is considered in the broadest sense, since there exist both financial and practical aspects to care that patients consider when facing bad news. The financial impact of cancer care is thus significant and can threaten the element of comfort many patients may have achieved—even the more successful patients.

Kolcaba's comfort theory is thus helpful in explaining the context within which bad news could be delivered to advanced cancer patients and their families.

More importantly, it addresses a key emotional (and safety) concern that should be considered for patients after they have received bad news, i.e., how a patient and their family moves past this bad news and feels a sense of comfort that may have been lost when the news first hit them. It is more than simply what their life is like afterward or what they talk about during the car ride home. The APN, in providing comfort and carefully assessing patients with advanced cancer, can be helpful in identifying issues that may have disrupted comfort (based on one of the four contextual frameworks discussed above) and develop a plan to help patients address their bad news. Consequent success would not only fortify the APN-patient relationship; instead, it would put the patient and family on a path were they are more engaged with the healthcare system.

Research Question

The primary aim of this project is to gain a better understanding of the skills necessary for APNs in medical oncology to deliver bad news. There is relatively little published on this subject. Research that has been published on this subject in nursing and medical literatures highlights many ongoing challenges that support additional research.

Project Justification

Development of the skill to deliver bad news is an individualized process and a topic that has historically received little attention in academic programs, including advance practice nursing (Eid, et al., 2009). Subsequently, most APNs learn how to deliver bad news through observing their attending medical oncologist, which explains the significant variation in this skill (Eid, et al., 2009). Other APNs have mastered this skill through their training and experience. Additionally, due to the consensus model of APN education, oncology-specific

APN programs have been phased out (Rounds, Zych, & Mallary, 2013). New graduate APNs, who may have strong clinical knowledge in general medicine, will not have the opportunity to specialize in oncology.

Summary

There thus remain several misunderstood challenges related to delivering bad news. The field of advanced practice nursing in oncology deserves a better understanding from a nursing perspective. Kolcaba's comfort theory is helpful in explaining the context within which bad news could be delivered to advanced cancer patients and their families. This theoretical framework provides a useful backbone for this project. Using a novel, patient-centered survey tool that has been designed to extract as much information as possible about the present issue from an expert panel, the goal was find a consensus. The outcome of this research could form the basis for an educational intervention for new APNs or those new to oncology. Additionally, the project aimed to define some such lessons for future APNs so that their basis of learning is from a nursing point of view.

CHAPTER 2: LITERATURE REVIEW

Introduction

Literature provided an important role in the development of this research project. Nursing literature, and more specifically advanced practice nursing literature, focused on the delivery of bad news to patients with cancer, is limited. Subsequently, literature focusing on how physicians are trained to deliver bad news was evaluated and analyzed. While there was a focus on excluding palliative care APNs who work in palliative care settings from the study, there was at least one informative article found that addressed a training approach for oncology APNs and is described later in this chapter. In total there are seven important articles reviewed which spans across the disciplines of medicine and nursing. Unfortunately, there has been a minimal focus on the role of the APN and thus provides additional justification for the current research.

Articles Reviewed

Fujimori, Shirai, Kubota, Katsumata, and Uchitomi (2014) performed a randomized controlled study of 30 oncologists recruited from the National Cancer Center Hospital in Tokyo, Japan. They enrolled 1,192 corresponding patients of these 30 oncologists. The oncologists were randomized to either an intervention group (IG) who participated in a two-day communication skills training (CST) program or the control group (CG) that received no additional training. The aim was to determine the impact of communication skills training (CST) on the oncologists' performance when delivering bad news (Fujimori et al., 2014). CST may be effective in improving physician communication; however, there is no evidence to support the potential impact on patient mental health or stress (Fujimori et al., 2014).

Fujimori et al. (2014) developed a CST based on the 4 factor/27 element SHARE model: S—setting up a supportive environment, H—considering how to deliver bad news, A—discussing additional information, and RE—reassurance and emotions. Demographics of oncologists and patients were compared using χ^2 or t test. Fujimori et al. (2014) calculated the consultation time and the change from the baseline. Moreover, they administered follow-up surveys of factors related to the oncologists' performance and the total score of the oncologists' confidence questionnaires.

Analysis was performed using ANOVA with a controlled baseline data. Levene's test for quality was performed for both groups (IG and CG). Based on their power calculations, 13 oncologists were required in each group for the power of 80% at $\alpha=0.05$. The statistical significance was set at $p<0.05$. Analysis was performed using SPSS. The enrollment of female oncologists was significantly higher than males'. No other difference in oncologist participants was observed. One-way ANOVA demonstrated a significant difference in three of four factors and seven of 27 categories of SHARE, including a significant difference in the oncologist confidence of SHARE (IG: $\Delta=22.5 \pm 34.4$; CG: $\Delta=-17.1 \pm 26.1$; $F=13.7$; $P=.001$) and in communicating bad news (IG: $\Delta=19.2 \pm 19.6$; CG: $\Delta=-2.4 \pm 15.4$; $F=11.2$; $P=.002$). There was no difference in patient distress at the baseline.

Fujimori et al. (2014) do not describe any statistically different baseline patient characteristics, besides the cancer type and current treatment status. The Japanese version of the Hospital Anxiety and Distress Scale (HADS) was used. A significantly lower HADS-D (for depression) and higher trust rating was found in the IG than in the CG during the follow-up survey. No significant difference between groups for HADS-A(anxiety) or patient satisfaction was observed.

Fujimori et al. (2014) demonstrated that CST significantly lessened the patient's distress and the oncologist's performance and confidence in a randomized study. Through the CST, oncologists in the IG learned new empathic skills, including how to accept silence and patient's emotions, use clear language to describe clinical details, and maintain eye contact (Fujimori et al., 2014). Using these skills did not result in any increase in the physician's consultation times. There exist several limitations of which the cultural differences between Japan and the rest of the world are possibly the most notable. The other limitation is that this study was just performed in one institution. Further studies should look at expanding this to other sites and countries. Moreover, it would be interesting to include APNs in this study as a subgroup.

Bylund et al. (2010) collected a convenience sample of 36 oncologists at the Memorial Sloan Kettering Cancer Center in New York, NY. The goal was to asses a customized CST for oncologists based on the Comskil Conceptual Model (CCM). Bylund et al. (2010) describe the CCM as based on two theoretical communication frameworks: person-centered communication and Goals, Plans, and Actions Theory (GPA). 36 physicians volunteered to participate in a CCM CST training program of 5 separate 3-hour modules, which included a didactic presentation, videos showing skills, and role play. Physicians were videotaped four times during real outpatient consults: twice before the trainings and twice after. Data on 28 physicians was analyzed. Videos were coded by trained coders based on Bylund et al.'s (2010) custom-designed coding system, adapted specifically for this CST training program. Bylund et al. (2010) described a coding system that codes for skills when present, but not for nonverbal behaviors. Coder reliability is reported as acceptable with Cohen's Kappa=0.84 and correlations range from $r=.70$ to $r=1.0$ ($p<.001$). Coders were not blinded pre- or post-training.

Skill set frequencies and the frequencies of individual skills were analyzed, mostly using paired *t*-tests. 112 videos of doctor-patient consults were analyzed—61% new patients and 39% follow-up visits. The average time of consults did not differ pre- or post-training. There were three skills used frequently at the baseline: questioning skills (QU), empathic communication skills (EMP), and information organization skills (INF). These were used four times more frequently than establishing the consultation framework skills (EST), checking skills (CH), and shared decision-making (SDM) (Bylund et al., 2010). Demographic differences— primarily, gender and the amount of training—had no impact. Bylund et al. (2010) reported that surgeons were more likely to use the skill of *preview information* than non-surgeons ($\chi=3.83$ *vs. 1.56, p<0.05)*. Skill difference changes from baseline were noted between physicians who attended more vs. less training. Overall, Bylund et al. (2010) reported participants demonstrated a significantly increased use of the EST (p<0.01) and CH (p<0.01). For physicians who attended more modules, the *preview information* significantly increased. For all non-significant findings, trends indicated increases in the usage of skills post-training.

The study had several limitations. It was conducted at one institution and the participants were voluntarily self-selected. There was no randomization or control group. Results were compared against the baseline characteristics for participants who had elected to be included. Non-verbal cues were not evaluated by the coders; there could have been significant losses in the evaluation of the overall experience by excluding this component. There was no measure of patient outcomes, either to correlate or with the CST intervention. A larger study including other institutions, advanced practice providers, and patient feedback would be helpful to validate the results.

Eid, Petty, Hutchins, and Thompson (2009) performed a study on eight participants, six hematology-oncology fellows, and two advanced practice nurses, at an academic medical center in Texas. The interest was in learning if an educational intervention would improve the skills of new oncology providers in delivering bad news (Eid et al., 2009). Using a standardized patient (SP), participant evaluations were first video-recorded and, again, a week after an educational intervention. Eid et al. (2009) created an educational intervention that consisted of a lecture, the distribution of laminated cards with the SPIKES methodology on them, and the observations of investigators interacting with the SP in a series of role-playing exercises. This study had a complicated method and design that utilized a highly subjective quantitative tool (a 21-item checklist based on the SPIKES methodology); this included a form of a 360-degree feedback (the checklist was completed by participants, faculty, and the standardized patient) and repeated at multiple time points. Eight participants completed the pre-intervention session; six completed the post-intervention session. Only one APN participated in both the pre- and post-intervention sessions. The average score of performance improved from 56.6% (before intervention) to 68.8% (after) ($p<0.005$; Cronbach's $\alpha=0.66$). Participant perception improved from pre- to post-intervention but was not statistically significant. The long-term intervention perception study showed that values for all participants (n=6) were positive. There were several limitations to this study—most notably, the small sample size, which included just one APN who had participated in both intervention analyses. The investigators should have considered the use of a standardized and externally-validated evaluation tool.

Wilkinson, Perry, Blanchard, and Linsell (2008) performed a multi-center, two-armed, parallel-group pragmatic randomized controlled trial (RCT) of 172 nurses to evaluate the effectiveness of a three-day CST course in changing nurses'

communication skills regarding the delivery of bad news. Participants were recruited from 10 different hospice and community nursing service locations across the United Kingdom (UK). The primary objective was to test a hypothesis that nurses' communication skills would improve after a three-day CST vs. those who did had not taken the course. Secondary outcomes included the following: determining if the nurses who attended CST would have more confidence and if patients would have a lower anxiety level and higher satisfaction if cared for by a nurse who had attended CST vs. those who had not. After eligibility and consent, nurses recorded the audio of the first two eligible patients admitted to their clinical area after a specified date. After gaining patient consent, the nurses completed the pre- and post-interview questionnaires.

Wilkinson et al. (2008) provided questionnaires to patients in stamped/addressed envelopes for confidentiality. The nurse demographics and training details were collected at the baseline. After the nurses had submitted their first two recordings, they were randomly assigned to a three-day course or to a control (no course). Two additional patient interviews were submitted at 12-weeks from both IG and CG. A sample size of 160 was calculated, required for 90% power at the 5% significance level. Attrition of 20% was assumed. Randomization was based on a random number sequence using a computer randomized number generator, stratified for the 10 course locations. The independent rater was blinded regarding whether audio recordings were from the IG or CG and whether they were at the baseline or at 12 weeks. Primary analysis was based on the intent to treat population (ITT) using Stata version 9.0. All tests were two-sided with p=0.05 significance. Wilkinson et al. (2008) analyzed the change in communication skills and nurse confidence scores using repeated measures analysis of variance to include those nurses with data at only one time point. The

p-value was corrected for the lack of independence of observations at two time points using Box's conservative correction factor.

Wilkinson et al. (2008) compared the 13 areas of assessment separately between the two groups of nurses using ordered logit estimation. Patient anxiety was analyzed using a paired *t*-test and the analysis of variance. Wilkinson et al. (2008) demonstrated that the IG score increased by 3.36 points. Differences in the change between IG and CG was at 3.41 (95% CI: 2.16–4.66, *p*<0.001). For nurses with complete data, 94.3% of IG showed improvement following the course vs. 49.4% in CG. The secondary outcomes were as follows: nurse confidence scores—IG increased confidence by 18.6 points and decreased CG by 0.7 points. There were no statistically significant changes in patient anxiety. GHQ-12 scores demonstrated that patients assessed by nurses in IG had a more positive general emotional state than in CG. Patient satisfaction improved in IG (Wilcoxon rank-sum test, *p*=0.02). 17% of nurses' skills (unclear if IG, CG, or combined) deteriorated or stayed the same. This is thus a valuable study with some technical limitations. Audio recording, while helpful to keep raters blinded to the IG and CG, neglects the evaluation of non-verbal cues. Another limitation is that the study was performed in the UK; one must thus take into account cultural differences between the UK and the rest of the world. This study could be replicated in a larger sample and could include APNs.

Volker, Kahn, and Penticuff (2004) performed a descriptive naturalistic designed to establish the preferences of adult cancer patients as they faced end-of-life (EOL) care, and to learn strategies used by APNs to help patients achieve their designed control at EOL. Participants were interviewed; the recorded interviews were analyzed using Denzin's model of interpretive interactionism. They had nine participant APNs recruited from the Oncology Nursing Society membership roster

in Texas. Volker et al. (2004) described Denzin's process to include the following: reviewing transcriptions multiple times and looking for key elements, structures, or statements. Textual phrases were labeled and their interactions where considered. Thereafter, themes were presented to address the study question.

Volker et al. (2004) determined two main categories of information. First, the APNs' experience with what their patients desired regarding control and comfort at EOL. A thematic analysis found the four following themes: engagement with living, turning the corner, comfort and dignity, and control over the dying process. The second category that Volker et al. (2004) established was the APNs' description of their role in assisting patients gain control and comfort at EOL. Thematic analysis of this second category found the three following considerations: processing bad news, managing physical care and emotional needs, and facilitating care services. Volker et al. (2004) suggested that interview data demonstrated two areas of Lewis' conceptual typology of control— processual control and behavioral control. Volker et al. (2004) validated that APNs require education on how sensitive information is to be communicated.

This study had some limitations. Participant APNs were Caucasian, middle-aged women who practice in Texas. A larger and more diverse study population is thus required to determine the study's applicability outside this area. Interview data was collected in relation to patients in general, and not one specific patient. This type of interview approach, with a lack of exact examples, could lead the APNs to focus more on generalizations than exact principles.

Stadelmaier, Duguey-Cachet, Saada, and Quintard (2014) performed an intervention study of an assessment tool—Basic Documentation for Psycho-Oncology (PO-Bado)—with a group of oncology nurses in France. The context was the French "Breaking Bad News in Cancer Plan," which "aims to improve the

delivery of the cancer diagnosis and to establish adapted personalized patient support" (Stadelmaier et al., 2014, p.307). This is a very interesting program, heavily reliant on the oncology nurse to be the primary provider in the "clinical support stage" (temps d'accompangement soignant (TAS) in French) (Stadelmaier et al., 2014, p.307). This stage is described by Stadelmaier et al. (2014) as the step after patients receive their medical information but before they are referred to other services. The TAS consultation was a 45-minute meeting oncology nurses had with patients after they had met with the oncologist, where the patients could clarify the received information and the nurse could screen the patient for other services patients might need and refer them as is appropriate (Stadelmaier et al., 2014).

The PO-Bado is an instrument designed and validated in Germany; it has been adapted, although not scientifically validated, to be used in France (Stadelmaier et al., 2014). It is a structured, psychosocial screening tool that nurses can use during the course of consultation with patients and is focused on the subjective elements of the recent patient experience (Stadelmaier et al., 2014). Stadelmaier et al. (2014) wanted to determine how patient experience and nurse satisfaction differed between those nurses performing TAS with and without the PO-Bado tool. Furthermore, the study was interested in learning if providing an educational intervention that taught nurses PO-Bado would result in an improvement in their TAS patient outcomes and in the nurses' satisfaction. A study was conducted with 15 nurses (four with PO-Bado experience and 11 without); it observed 62 TAS consultations with patients. The study took place in France at four different hospitals including a large, small, military, and a community hospital; all involved nurses had at least six months of experience in performing TAS consultations. One selected hospital had been using PO-Bado as

part of their TAS consultations for three years; four nurses from this hospital agreed to participate as the PO-Bado-experienced group.

Stadelmaier et al. (2014) analyzed the content of each TAS consult qualitatively to determine the frequency of using communication techniques and to identify the themes most important to patients. Two psychologists performed the analysis separately; they then met to combine their results into a single version. Stadelmaier et al. (2014) used the Fallery and Rodhain procedure with the NVivo software for the analysis and coding of consultations. SPSS was used for statistical analysis of frequencies using the student t-test (confirmed by the Mann-Whitney U-test) given the small sample size. They reported results in four main categories. First, Stadelmaier et al. (2014) compared the TAS techniques of experienced and inexperienced nurses before training. Here, they found that nurses experienced with PO-Bado were 48% more likely ($p<0.01$) to utilize techniques promoting patient expression. Moreover, they reported that communication which focused on the "subjective experience of the patient" (Stadelmaier et al., 2014, p.310) was 46% more frequent ($p<0.01$) in the experienced group. In this baseline analysis, there was no difference observed in the "use of techniques not promoting patient expression", the "frequency of informative sequences", or the "statements regarding the history of patient's illness" (Stadelmaier et al., 2014, p.310).

The second comparison looked at the PO-Bado techniques of inexperienced nurses before and after the PO-Bado training. It was found that these inexperienced nurses used techniques that would "promote patient expression" (Stadelmaier et al., 2014, p.310) 57% ($p<0.05$) more often after training and this demonstrated the overall improvement in the consultation quality. Third, there was no change in the amount of time taken by the TAS consultation; in fact, it was reported that the TAS consultations post-training for inexperienced nurses

shortened by about seven minutes using PO-Bado. Additionally, the study measured the rate of referral to psychologists, noting that inexperienced nurses were more likely to refer to psychology before the training (66% before training, but only 42% after training). Lastly, the post-training referral rates were similar in both the experienced and inexperienced groups of nurses. Nurse satisfaction in the inexperienced group after the PO-Bado training was generally high (mean=8.5, SD=0.8 on a scale of 1 to 10). This becomes a helpful study to evaluate if a structured technique can improve supportive communication skills to patients with cancer and improve nurse satisfaction and confidence. Moreover, it is a good example of how using a structured process does not add to the nursing consultation time.

However, this study did have the following limitations. It took place in France. The application of these lessons, in particular, the PO-Bado tool, is limited. There was no direct evaluation of patient satisfaction. Lastly, the study involved registered nurses and not APNs.

Tanco et al. (2015) performed a randomized controlled study (RCT) to evaluate the patients' perception of compassion. The research team was interested in learning if the tone of a message to patients with advanced cancer (more optimistic vs. less optimistic) had an impact on how the patient perceived compassion and if it impacted the physician's trust. One hundred patients from an outpatient supportive care clinic at a major academic medical center in Texas were randomized to watch two standardized, four-minute long videos portraying a physician sharing treatment information with an advanced cancer patient. One video depicted a more optimistic message, while the other showed a less optimistic message. Both actors (physician and patient) were blinded to the purpose of the study. All four videos contained the same message and the actors

were instructed to act in the same manner, including using the same body language. The videos contained five empathetic statements. English-speaking adults with advanced cancer being cared for at a Supportive Oncology clinic were included in the study. An extensive patient demographic table was presented in the completed article. In summary, the median age was 57. The population consisted of 52% females, 78% Caucasians, 80% Christians, and 74% people who had metastatic cancer. Eligibility was assessed for 313 patients; 100 were enrolled and randomized in a 1:1:1:1 fashion to one of four groups. The randomization ensured that all 100 patients saw one video from each MD actor; half viewing the optimistic video first, while the other half viewed the less optimistic video first. Tanco et al. (2015) were concerned about the sequencing effect. Data was collected using several validated tools including the Edmonton Symptom Assessment System (ESAS), HADS, the Hearth Hope Index, and the Peace, Equanimity, and Acceptance in the Cancer Experience (PEACE) scale. After watching each video, Tanco et al. (2015) had the patients evaluate the physician who had delivered the message and rate their compassion, stating their preference and reasons for the same.

To measure their primary outcome, i.e., physician compassion, Tanco et al. (2015) used a five-item tool of five numerical ratings on a scale of 1 to 10, which assessed the following five dimensions: warm/cold, pleasant/unpleasant, compassionate/distant, sensitive/insensitive, and caring/uncaring. This yielded a score for each physician on a scale of 0 to 50. The results were interpreted inversely with lower scores indicating a higher level of compassion. This tool was developed by external researchers and has been utilized in several other studies. The internal consistency of the scale used to asses compassion was demonstrated by a Cronbach $\alpha=0.92$. The reliability of the other seven tools used were also

discussed. The sample size of 50 patients in each group (n=100) allowed Tanco et al. (2015) to maintain 80% power for a two-sided two-sample t test; they were able to detect an effect size of 0.57 with a type I error rate of 5%. For the primary outcome, reviewing the survey results after the first video, physician compassion was found higher after the more optimistic video as opposed to the other (median [interquartile range {QR}], 19 [9–27] vs. 26[14–34]; t=-2.67, p=.009). It is important to note that lower scores indicate higher physician compassion.

There was no statistically significant difference in the scores across the two different physician actors. In their final analysis, Tanco et al. (2015) demonstrated that physicians who delivered a more optimistic message were perceived to be more compassionate when compared to equally empathetic physicians delivering a less optimistic message.

The Tanco et al. (2015) study had several strengths. First, the sophisticated study design allowed for a true comparison of the two messages offered to the patient. A significant concern was what the authors termed as the "carry-over" effect. This was where, when watching the two scenarios back-to-back, the first could in some way effect the perception of the second video. This issue was addressed in the crossover analysis. Another strength was the power. The researchers screened nearly twice as many patients as those enrolled, ensuring that all respondents met the eligibility criteria—they enrolled 100 patients. There were a few concerns or weaknesses. First, the study enrolled patients being seen in a supportive care cancer clinic at a major academic cancer center. In most cases, these patients had a lot of experience with the cancer care system and had likely all received bad news at several points along their cancer journey. It is thus important to consider how their prior experiences could impact their perception of the physician actor and the message of the videos. While this is not entirely clear

from the description, it is possible that the supportive cancer clinic at the study location may be considered part of a palliative care clinic at other institutions. My concern is that patients who are being seen in a similar clinic may have come to better terms with their cancer diagnosis, and as such, may have interpreted the videos differently than someone with a fresh diagnosis.

<div align="center">**Gaps in the Literature**</div>

There are several important gaps in the literature, since it relates to the delivery of bad news to patients with advanced cancer. First, there exists little published research on the role of APNs in delivering bad news. The Volker, Kahn, and Penticuff (2004) study focused on APNs (nine female APNs from Texas). The Eid et al. (2009) study included two APNs, but only one completed both the pre- and post-intervention interviews. These are all old studies but their inclusion in this review was important because they represent the relatively small body of literature surrounding this topic.

There do exist studies of the registered nurse role in delivering bad news; however, these are not from the United States and they mostly took place within the socialized healthcare systems in Europe. While socialized healthcare systems may have multiple benefits to providing efficient care, there are some assumptions regarding EOL care and futility that do not correlate with current American expectations. For example, socialized systems are generally more open to discuss futility – a topic which has historically been considered controversial in the United States.

There exist multiple studies considering the role of the medical oncologist in delivering bad news and one eloquent study concerning the role of compassion and empathy (Tanco et al., 2015). These have only involved physicians, despite

having had taken place at major academic medical centers, neglecting the role of the community provider. Furthermore, there exist a variety of opinion-based editorials in nursing and APN literature regarding the delivery of bad news. However, based on this review, there has been no study that solely focuses on APNs in a variety of different settings using a consensus-building technique to determine what skills are necessary in delivering bad news to patients.

Summary of Literature Review

This literature review provided important background for the type of studies that are possible to better understand the delivery of bad news to patients with cancer. While there remains a significant gap regarding literature focused on the role of the APN, learnings from these studies, particularly those which included the patient perspective, provide important insights to what elements of this process patients may view as important. It is out of scope for this project, but inclusion of the patient perspective on the delivery of bad news is an important factor to consider.

CHAPTER 3: METHODS

Introduction

To accomplish the objectives of this study, a unique and novel survey tool had to be developed. This survey tool which is described in this chapter, enabled the collection of information from the expert panelists who participated in the project. The Dephi technique was used as a guide for both the development of the tool and structure of the tool. Collectively, the survey tool and the Delphi technique serve as the basis for the methodology of this project.

Delphi Technique

The Delphi technique, developed originally by Dalkey and Helmer at the Rand Corporation in the 1950's, is a widely-accepted technique to collect knowledge from experts in the field (Hsu & Sandford, 2007). This technique can achieve multiple goals, but the primary focus is to explore and expose assumptions (Hsu & Sandford, 2007) using a group of experts. In this project, the experts are experienced APNs currently working in a medical oncology setting. This is an iterative process which has been adapted from the work published by Hsu & Sanford (2007). In the first round, the electronic survey with open-ended questions was sent via Qualtrics to the panelists. These initial open-ended questions were developed based on issues identified in the literature review and this is an accepted practice in the Delphi process (Hsu & Sanford, 2007). The responses collected were reviewed by the investigator. For the second round, the summarized answers from the initial questionnaire were sent back to the panelists. They were asked to review and rank these summarized responses in order of importance and the goal of this step is to identify early areas of agreement or disagreement (Hsu & Sanford, 2007). This data was collected and summarized by the investigator.

Panelists

Participants in this qualitative research, using the Delphi method, are referred to as "panelists" (Kenney et al., 2001). These panelists were recruited through the personal professional network of the Principal Investigator. They were initially contacted via Facebook Messenger and asked about their interest to participate. Those who responded affirmatively were sent an informed consent form, using the electronic AdobeSign system. Each panelist reviewed the form and returned an electronically signed copy of their informed consent.

Survey Tool

A novel questionnaire was developed to initiate the Delphi process with the panelists. A full copy of the surveys are available in the Appendix A and B. The questionnaire process was anonymous—panelists were not aware of other participants. The IP addresses were automatically captured such that the geographic distribution of the panelists could be displayed. The questionnaires were secure—personalized links were sent to the consenting panelists. The secure link was only accessible to the panelists and could not be forwarded to other participants. Individual links were available for seven days once sent.

The structure of the survey tool was intentionally built around a patient story to encourage panelists to think holistically about the experience. The patient was at the center of the discussion. Several elements of the human experience were addressed in subsequent questions, including the physical, psychospiritual, sociocultural, and environmental factors (Kolcaba, Tilton, & Drouin, 2006). There was no available survey tool to assess these skills; thus, a novel tool had to be developed for use. Due to limitations of time and resources, this survey was not validated for use in this population.

The surveys were sent to panelists using the Qualtrics tool provided to students of the California State University. Twenty-six questions were developed to evaluate multiple aspects of the process of delivering bad news to patients with cancer. The first 10 were background demographic questions. Then, posed questions asked panelists to describe a recent event when they had been required to give bad news to a cancer patient and during which they had felt comfortable in doing so. This story, with its nuances, was the departure point to lead panelists into identifying the key issues for consideration when delivering bad news to a patient. Panelists were then presented with a series of open-ended questions. These had been developed based on issues identified in the literature review; this is an accepted practice in the Delphi process (Hsu & Sanford, 2007).

In an effort to retain involvement of the participants and maximize use of their time, the first round of the questionnaire was extended to include elements traditionally found in the second round. The first round is usually designed to determine the chief issues that underpin the subject of the study (Keeney et al., 2001). The second is to collect opinions about these identified topics (Keeney et al., 2001). As an example of how both rounds were combined, the survey started by asking panelists to describe a recent situation where they had had to relay bad news to a cancer patient and had felt comfortable in doing so. This question and subsequent discussion (in the case of an in-person panel) would have been enough to satisfy the first round, since key issues were identified. For the purposes of this survey tool, the story became the starting point to collect opinions about the identified topics, which is essentially a round two discussion.

The questions following the story were aimed to collect opinions from the panelists. This part could have been included in a second round of surveys had a traditional Delphi approach been used. Multiple questions focused on the

panelists' opinions of the setting, body language, and other participants in the room when delivering bad news. Panelists were asked to compare and contrast a recent experience of delivering bad news with one that they could recall from an earlier practice experience. While this was not explicitly asked, all panelists described their feelings and confidence, or the lack thereof, in delivering bad news from early on in their careers to the present time. The survey concluded with questions regarding the necessary skills to deliver bad news and the best format to learn such skills. These were open-ended questions; suggestions as to what these skills may be or how best to learn the same were not provided to the panelists. Panelists had to suggest their top recommendations.

The second round of surveys took these top skills and learning methods, asking panelists to rank the same. This ranking process led the participants towards a consensus.

Data Analysis

Content analysis was used to evaluate obtained qualitative data. The conceptual basis for this type of analysis has been demonstrated in other similar nursing studies including the work of Whiting and Cole (2016). Their work used a Delphi study to develop a trauma care syllabus for intensive care nurses. They utilized an adapted version of Burnar's method of content analysis, which was further adapted for this work. This process, well described by Bengtsson (2016), includes decontextualization, recontextualization, categorization, and compilation. Whiting and Cole (2016) developed very strong results from the Delphi study with nurse experts in the intensive care field. There are multiple benefits to content analysis for qualitative researchers; the most relevant to the present work is that this allows for the development of new knowledge and insights (Elo & Kyngas,

2007). As a pilot project, such insights could be used to guide the structure of a future, more robust, controlled trial of intervention.

The data that was collected was carefully reviewed; the content was organized based on its meaning. Responses are to be categorized into similar or related topics to allow for a concise list to identify primary and secondary themes. Descriptive and frequency statistics of each topic were calculated. This included include statistics that reflect the amount of agreement among the participants, the ranges (minimum and maximum), means, and medians. SPSS version 23 (IBM) was used for these calculations. 50% agreement among the participants is generally considered a minimum for consensus development (Whiting & Cole, 2016). Similar to the Whiting and Cole (2016) study, three levels of agreement are to be reported: low (>50–<60%), medium (>60–<80%), and high (>80–100%).

Summary

The unique and focused nature of this project required a novel survey tool and adaptation of a widely used consensus tool. Recruitment of participants is a challenging part of any study. While the personal professional network of this investigator yielded a highly trained and experience panel, the overall size of the panel was small. The small sample size made the development of a statistically powered consensus impossible to calculate. However, the results of the stories and collected responses yielded significant qualitative findings that can be useful in future research.

CHAPTER 4: RESULTS

Introduction to Results

This qualitative study aimed to determine the skills necessary to deliver bad news to patients diagnosed with cancer. An expert panel of APNs experienced in the field of oncology were surveyed using a novel survey tool designed to develop a consensus using the Delphi method. Participants in qualitative research using the Delphi method are referred to as "panelists" (Kenney et al., 2001). The qualitative analysis of the data derived is described here. Detailed information on the panelists to the extent that it was collected and can be de-identified to protect individual identify will also be presented. These details provide the context for understanding the themes that the panelists proposed. The overlap of themes, which supports the development of the consensus, will also be discussed.

Panelists

Twenty-seven panelists were identified and sent forms for informed consent. Fifteen panelists signed and returned the consent form and thirteen completed the first survey tool. Of the thirteen panelists, 100% were female. One survey was incomplete as the panelist stopped at the third question. Those results have been censored. The median age was 45 (range 31–57). States represented included California, Washington, Colorado, and Connecticut. Most panelists (92%) had a Master of Science in Nursing. One panelist was a Doctor of Nursing Practice. All panelists identified as Caucasian. However, one identified as bi-racial Caucasian and Asian. Forty-six percent of the panelists have been practicing as an APN for 5–10 years, 7% for 10–15 years, 30% for 15–20 years, and 15% for over 20 years. Ninety-two percent of panelists stated that they work at an academic medical center. One panelist works at a privately owned community practice.

Thirty-three percent of the panelists described their primary practice setting as inpatient clinics and 66% in outpatient clinics. Eight panelists (62%) described their practice style as "very independent – sees most patients independently", two panelists described their practice style as "somewhat independent – have some clinics alone, some joint clinics with attending MD", and three stated that they have mostly joint visits with an attending MD. All twelve panelists who completed the first survey identified as being fully employed as an APN, specializing in medical oncology (inclusive of hematology).

Table 1.

Characteristics of Study Population.

Study Population	
Panelists (n)	12
Gender Female Male	 12 0
Age (median)	45 (range 31-57)
Length of experience (yrs) < 10yrs 10–15yrs 15–20yrs > 20yrs	 46% 15% 31% 8%
Education Master's Degree in Nursing Doctor of Nursing Practice	 92% 8%
Practice Style Independent Joint Clinic with MD	 67% 33%

Panelist Stories

Twelve APNs submitted patient stories. These stories were predominately written about male patients. Only one APN wrote a story about a female patient – another did not use pronouns that would enable gender identification. Most of the stories were only a few sentences long but ranged in length from 12 to 359 words. While the original research plan included decontextualization, recontextualization, categorization and, finally, compilation, this process proved difficult to accomplish given the brevity of the majority of the stories. Instead, these stories have been categorized and the major themes have been identified by analyzing the content of these stories.

Table 2.

Categorization of Panelists' Stories (Frequency presented as a percentage)

Categorization of panelists' stories	Frequency (%)
Relapse after adjuvant therapy	16
Disease progression on imaging or lab work	50
Progressed on all standard of care therapies	25
Therapy-related toxicity	8

Categorization

Two of the patient stories were regarding patients who had relapsed on adjuvant therapy and developed metastatic disease. Adjuvant therapy is given to patients with cancer after definitive surgical resection of the tumor(s). The goal of adjuvant therapy is to reduce the risk of the cancer recurring. In oncology clinical trials, this is referred to as recurrence-free survival. Patients who elect to receive adjuvant therapy, and the medical oncologists who prescribe it, do so with the expectation that the risk of the cancer recurring will be lower. Thus, it can be very

difficult to explain to a patient who underwent adjuvant therapy that the cancer has, indeed, recurred. Six of the stories were based on discovering disease progression as the result of an imaging study or lab results. These six patients already had advanced or metastatic disease but had undergone some sort of anti-cancer therapy, only to find out that the therapy was ineffective in controlling the disease. This included one patient who had been in remission for a several years and doing well but, recently, had received laboratory data suggestive of recurrent disease. In three of the cases described, there was no other standard of care option left for the patient to try. This included one patient who had already exhausted all known/approved therapies and tried a Phase 1 agent from a clinical trial as a last line of therapy. One patient story was regarding a patient who was dying due to the side effects of cancer therapy. All of the stories were indicative not only of the complexity of the situations that the APNs faced on a regular basis but also highlighted the challenging situations within which they have to deliver bad news.

The following story stood out as an exemplar. It eloquently describes the complexity of multidisciplinary care, and how an APN is the medical professional at the end of the road who ultimately has to put together all of the pieces of bad news for the patient:

A patient I had taken care of one week ago for a new seizure was being re-admitted with a bowel perforation. Palliative care had already seen the patient and family in the ED and in speaking with the family and after speaking with their primary oncologist they wished to pursue CMO [comfort measures only]. However, they had not yet discussed this with the patient at the time of his arrival to the floor. I called the primary oncologist to get further background regarding his conversation with the family and then spoke to the daughter outside the room to get a sense of where the

family and where the patient was. She felt her father needed to hear the prognosis, an update on what's going on and what we should do next. I went into the room. His wife of 44 years was there along with a few other family members and his daughter. The patient laid in bed and looked somber. I pulled up a chair next to his bed and first asked him what his understanding was of the situation. He started with "not really sure. I've kind of half understood everything". I started with what I had heard brought him into the hospital and what was found on his CT scan. I went through surgery's recommendations (which was no surgery given his comorbidities and that the risk would be too great). He stated he understood. I then spoke to them about my conversation with their primary oncologist and that it's our recommendation to focus on keeping him comfortable and treating his symptoms. I elaborated that this means if he had pain, we would treat the pain. If he had nausea, we would treat the nausea. And that this would mean we would allow for a natural death should his heart stop and he were to stop breathing. He asked me how long he has and I said it could be hours to days. He also asked if he's going to be in pain and I said our goal is for that not to be the case. He agreed that this is what he would like to do.

This story is representative of the challenges that many APNs in oncology face when having to deliver bad news to patients with cancer. Additionally, it highlights many of the salient issues raised by the other panelists across their stories and form the basis for a discussion around the dominant themes.

Identification of Themes

Using the stories that were submitted by the panelists and their subjective responses to the questions that followed the stories, the following themes were

identified. While all themes were not prominent across all panelists' feedback, the themes discussed represent the dominant messages that most panelists were trying to convey either through their story or the subsequent survey responses.

Rapid decline. The rapid decline in health faced by many patients was highlighted as an important issue in the above story. "One week you are focusing on an acute problem, and then in very rapid order you can be faced with a life-ending situation" wrote one of the panelists. Of the twelve stories that were submitted, four of them spoke about a rapid change in the health status leading to having to deliver bad news.

Complex care team. For better or worse, the emergency department is commonly involved in the end-of-life care for patients with advanced cancer. The environment in most Emergency Departments is exactly opposite of what most individuals consider to be a peaceful end of life. According to the panelists who wrote about the Emergency Department, this area of the hospital is filled with clinicians who are unfamiliar with oncology care, may not understand the role of the mechanisms that various cancer therapeutics patients may be on, and are charged with making decisions quickly. As demonstrated in the above story, they were very quick to make a decision – in this case, calling Palliative Care. Although there was family support for the decision, it is clear from the story that the patient himself did not really understand what had occurred. While it seemed as if there was a fairly thorough medical assessment of the patient's condition (surgery, medical oncology, etc.), the decisions were made quite quickly and it did not sound like they had a family meeting that included the patient. It was the APN working in the role of the hospitalist who had to put together the story for the patient and his family.

Communication with the team. In the story above, the APN demonstrated that communication with other members of the clinical team was very important for collecting all the information required in order to be able to speak honestly and clearly with the patient and his family. This theme was evident in several other stories as well and was highlighted by the responses to the question regarding the most important skills. Proper knowledge of the data, scans, and the state of the disease (inclusive of collecting the corresponding information from the appropriate team member) was identified as the third most important skill.

Body language and positioning. The body language and positioning of the APN in the story above speaks of an issue that was raised by 40% of the APNs across all the stories submitted. Sitting with the patient, getting to their eye level, and being closer to the patient were identified as important elements of communicating effectively. Therapeutic touch is another element of body language that was asked of the panelists. Respondents were provided a 6-point scale ranging from "definitely yes" to "definitely not". 42% of the APNs selected "definitely yes" while another 50% said that therapeutic touch might or might not be a part of their visit. One APN said that therapeutic touch probably would not be a part of her approach.

Evaluate visual cues. Panelists were asked specifically about the visual cues that patients expressed while receiving bad news. The patient in the story above was described appeared somber. Most responses included anger, fear, frustration, and despair. Additionally, most panelists reported that patients also expressed agreement and were receptive to the information provided. Three panelists noted aversion of the eye and bowing of the head. Another panelist noted that the patient watched her eyes carefully and maintained contact the entire time.

Two panelists noted that the patients slouched in their chairs and one went on to describe the patient as in a "state of abject sadness." Panelists were then asked to describe the emotions that their patients experienced. Solemn, sad, distressed, and disappointed expressions were noted by most. Shock and disbelief were noted by one panelist.

An interesting element of visual cues that was discussed by three panelists is that patients watched them and their body language. These patients knew the panelist well prior to this visit. They had received news – both good and bad – from the panelists before and had a sense that they could tell how what the results were based on the panelists' body language. This element of visual cues is an important observation that reminds clinicians that the body language they exhibit may speak louder than the words they say or do not say.

Questions about the end. "Will I be in pain at the end?" is a question that several panelists either directly mentioned or alluded to in their stories as well as the subsequent comments in unstructured responses to other questions. This central theme in the panelists' reflection of delivering bad news demonstrated a clear strength that this panel of APNs bring to the task at hand. This is described in the story above as, "if you have pain, we will treat the pain… if you have nausea, we will treat the nausea." Another panelist wrote, "patients know that I am not afraid to be aggressive with pain and symptom management – some of them actually ask to see me specifically because they think that I do a better job at it than my attending does."

Preparation for Delivering Bad News

When the APNs were asked if they felt well prepared to deliver bad news, 45% felt "very well prepared" and 36% felt "extremely well prepared." One APN was only "moderately well prepared" and another did not feel well prepared. It was the APN who did not feel well prepared who also noted that the patient expressed shock and disbelief:

> …Had a patient come in urgently with complaints of abdominal pain that was not well controlled - he was getting adjuvant therapy at the time. Got CT scan and he had metastatic disease. His posture was poor and he looked shocked and in disbelief. Wife was present and she seemed surprised. Sometimes I feel that I have helped transition a patient into a more palliative care mode; other times I feel frustrated…

APNs were then asked to reflect on the experience they wrote about and what specifically they did to prepare for the visit. The most common response involved reviewing clinical data and treatment options thoroughly before entering the patient room. Many APNs noted that they had discussed the plan with the attending MD and the interdisciplinary team before speaking with the patient. This quote from one of the APNs speaks to the extent of preparation:

> ...in this situation I looked at the data, kinetics of her previous leukemia to order additional labs, I had gotten the lay of the land, support system, husband and her own history when I met her for the first time earlier in that visit. I thought about how to talk about it as she had been doing so well and felt great. I knew they would be blindsided.

When the panel was asked to reflect on their early career experiences of delivering bad news, most described this as something that was difficult, something they feared, dreaded, and was anxiety provoking. One APN reported

that this was something that she has always been able to do. Two APNs reported that part of the challenge of delivering bad news as a new APN was not really understanding the role of the APN or how far they should go so as not to encroach on the role of their attending MD.

> Early in my career, I so desperately wanted to ease their pain when they were hearing bad news, but I learned that there was nothing I could say to make it better so I learned to simply be present … I also learned key phrases like "I wish things were different".

> These "key phrases" were referenced by other panelists as well. Some noted that they had borrowed phrases from others that they had observed delivering bad news which speaks to the value of having a good mentor after which behavior and language can be modeled.

> The APNs were then asked how their practice changed over time. Most of the panelists noted that the process definitely evolved over time. They learned to slow down, developed a script that they are comfortable with, and learned how to take clues from the patient and their families which allows them to modify the approach if the visit is not going well. They developed confidence and greater understanding of the role of the APN and the disease areas they work in. Two panelists noted that they ask more questions than they used to –questions which they used to find intimidating to ask such as, "What is your biggest concern?" or "What do your kids know?"

Primary Patient Concerns

The subjects were then asked to describe the patients' primary concerns after hearing the news. The APNs noted that patients asked about side effects of the next line of treatment, concerns regarding pain control, what death would look

like, and fears about letting down the family. "Patient was concerned about letting her son down. Her son was encouraging her to fight. She did not want further treatment and was conflicted." This conflict between what the patient wants and what their family member or caregiver wants was a significant theme. There was a lack of consensus as to what type of family situation was likely to lead to this challenge, although both examples noted by panelists were driven by the patients' children as opposed to the spouse.

Relationship

The APNs were asked what their relationships with patients were like after the visit. While one APN noted that the relationship was unchanged, all the others noted that the relationship was very good, improved, or even stronger than before. This quote describes one of the responses: "They both thanked me and hugged me at the end of the visit. They said that they appreciated the unpressured time (I spent over an hour with them) as well as the honesty about the poor prognosis." There was consensus among the panelists that the relationships were either unchanged or improved, none described a situation where the relationship was worse.

Situational Details

When asked if the patient was alone for the visit or accompanied by a family member or friend, most APNs reported that the spouse was present (in most cases, a wife was noted). One son, two daughters, and one friend were present. Two patients were alone. For the patients who were alone, they were both noted to have complex family situations. One patient was a young man whose mother had substance abuse issues. No details were provided for the second patient who was alone. If a spouse or a family member was present, the APN was asked to describe

their response. Supportive, strong, and stoic was recorded as the dominant theme among the female spouses who were present. One daughter who was present was described as "angry and confrontational", the other was described as "distressed and anxious". Overall, it appears that wives responded better than the daughters, and that the one family that was present seemed to handle the situation with calmness and gratitude for the care their family member had received.

They were then asked if therapeutic touch is a part of their approach. Respondents were provided a 6-point scale ranging from "definitely yes" to "definitely not." Forty-two percent of APNs said "definitely yes" while another 50% said that therapeutic touch might or might not be part of their visit. Collectively, this suggests that there is a consensus among the panelists as to the potential role of therapeutic touch. One APN said that therapeutic touch probably would not be a part of her approach.

Impact on the APN

An issue that was identified in the literature review is that continually delivering bad news may, over time, have a negative impact on the APN. To address this, the focus of the survey then shifted to the feelings of the APN herself after delivering the bad news. The responses to this question included a variety of different positions. Drained, defeated, sadness, and anxious were all mentioned as emotions that this group of APNs felt. Although the study was not designed or powered to find true correlations, there was a numeric increase in the number of panelists at the beginning of their careers (5–10 years of practice) who mentioned negative feelings. Three panelists noted that while it is a hard thing to do, there is a feeling of empowerment knowing that they have been able to be a part of the care of their patient, even if that care is to guide the patient towards a peaceful death.

"Drained but grateful for the opportunity to be able to be involved." These three panelists all had over 10 years of experience in the field of oncology and all worked in outpatient settings.

Skills Needed to Deliver Bad News

The panelists were asked to list the top three skills needed and the best way to learn how to give bad news. Responses to this question were provided in a free-text field. Seventy-five percent of the panelists identified more than one skill. Thirty-six skills in total were identified by the panelists and the nine most common skills (based on the frequency) were sent back to the panelists in the second round of surveying. They were asked to rank the top nine skills from most important to least important. Twelve participants responded to this round of survey.

Table 3.

Top Skills Identified by the Panelists (Listed as frequency)

Top nine skills identified by panelists	Frequency (number of times skill identified)
Empathy	6
Knowledge of data, scans, treatment options, and disease landscape	5
Honesty	4
Self-awareness	5
Active listening	3
Setting the right scene (who should be present, room setup)	3

Know your patient, their preferences, and their style of communication.	5
Self-preservation (ability to debrief with team to relieve pressure after meeting).	2
Take your time and be thorough (do not rush).	4

When asked to rank these skills, 42% of the participants felt that empathy was the most important skill, 16% of the participants ranked both active listening and setting the right scene as the most important skills. One APN felt that honesty was the most important skill, 25% of the APNs ranked empathy, honesty, and self-awareness as the second most important skill. Active listening, knowledge of data, and self-preservation were all identified by, at least, one participant as the second most important skill, while 42% of the participants identified knowledge of data, scans, treatment options, and disease landscape as the third most important skill. A quarter of the participants ranked self-awareness as the third most important skill. Honesty, active listening, setting the right scene, and self-preservation were all identified by, at least, one APN as the third most important skill. The most consistently identified fourth skill was knowing your patient, their preferences, and their style of communication. 16% of APNs felt that honesty, setting the right scene, and self-preservation were the fourth most important skills. 33% of APNs identified self-awareness as the fifth most important skill and 16% identified active listening or setting the right scene. For the sixth most important skill, 25% of the panel identified setting the right scene. 16% ranked knowing your patient,

their preferences, and their style of communication or self-preservation as the sixth most important skill. For the seventh most important skill, 25% of the APNs selected honesty and 16% selected empathy, self-awareness, or knowing your patient, their preferences, and their style of communication. The most uniform consensus was seen for the eighth most important skill. 83% of the participants felt that taking your time and being thorough fell into this position. The remaining 17% of the panel felt that self-preservation was the eighth most important skill. In the ninth and final, or least important position, self-awareness, knowing your patient, their preferences, and their style of communication, and self-preservation were the most identified skills, collectively representing about 75% of the panel. Honesty and active listening represented the remaining 25% of the panel.

The consensus was that empathy was the most important skill that APNs in oncology needed in order to deliver bad new to cancer patients. Honesty and self-awareness were identified as the second most important skill overall. Disease and data-specific knowledge was identified as the third most important and in the fourth position was knowing your patients' preferred communication style. When comparing these top four skills against the themes presented in the panelist stories, we see a striking resemblance. In the example, empathy (demonstrated mainly as emotional intelligence) was coupled with the knowledge of the data and a focus on communication skills. These three themes correspond with the consensus of the panelists on the top skills needed to deliver bad news.

Learning Methods

The final question asked APNs what they thought was the best way to learn the skill of delivering bad news. They initially proposed twelve methods, and the top four (based on frequency) were presented back to the participants and they

were asked to rank them in order of importance. The top four methods are detailed in Table 4.

Table 4.

Top Four Learning Methods Identified.

1. Practice
2. Focused Skills Training – Role Play
3. Observation – Have a good mentor and watch them deliver bad news.
4. Use a standardized tool such as SPIKES.

Forty-two percent of the participants recommend focused skills training – role play – as the most important skill. Practice was also highlighted as very important by 33% of the panel. Observation and standardized tools were only identified by a few participants as the most important skill. The second most important skill identified by 50% of participants was observation. The use of standardized tools such as SPIKES was also a dominant method with 25% of participants identifying that as the second most important. As the third most important method, 58% of participants selected practice and 33% identified focused skills training. As the fourth most important skill, 50% selected the use of a standardized tool such as SPIKES and 33% selected observation. Two participants felt that focused skills training was the least important of the four methods.

The consensus was that role play was the best way to learn the skill of delivering bad news to patients with cancer. Observation, practice, and the use of a

standardized tool such as SPIKES were identified in the second, third, and fourth positions respectively. This emphasis on practice skills is consistent with the themes of the panelist stories regarding situational details, understanding the patients' needs, and developing a relationship with the patient and their caregivers.

Summary of Results

These results represent a novel approach and the utilization of a practical consensus building tool that has utility in advanced practice nursing as well as in other disciplines. Using a story as the basis for collecting opinions about a skill that is unique and personal in the delivery of bad news, this panel of APNs came to a consensus regarding the skills and learning methods needed to teach new APNs or those entering into oncology on how to deliver bad news. While this method is not without its limitations, which will be discussed later, this method was effective in collecting valuable insights from a panel of expert APNs. Additionally, it was also an efficient method in that the total data collection took less than 30 days and was very cost-efficient as there was no need for live, in-person meetings. This flexibility made it easier for the panelists to participate and fit this project into their already busy professional and personal lives. The panelists shared intimate and insightful stories about delivering bad news to patients with advanced stages of cancer. Their stories formed the basis for the development of a consensus on the skills required to deliver bad news as well as the best methods to learn these skills. There are various ways that panelists could have more involvement in this project or more details could have been collected. The survey itself could have been longer and there could have been an incentive placed on completing additional rounds of questioning. A live face-to-face session with panelists also could have been helpful to collect additional insights.

Although not surprising, the consensus was challenging. Collectively, the panel identified key themes, skills, and learning methods that can be quite helpful as APN educators consider an optimized approach to teaching new oncology APNs.

CHAPTER 5: CONCLUSIONS AND LIMITATIONS

Introduction to Conclusions

The main objective of this study was to establish a consensus among expert APNs in oncology on the skills required to deliver bad news to patients with cancer. Through the use of a novel survey tool that was structured around the Delphi method of consensus building, a final sample of twelve panelists participated in this process. To this researcher's knowledge, these results represent the largest study of its kind that aimed to achieve this objective.

APN Stories and Skills Identified

The APNs in oncology who participated as panelists in this project shared intimate and eloquent stories about their experiences in delivering bad news. The stories became the blackboard upon which panelists were asked to draw from their own strengths, fears, and the preparation they underwent for delivering bad news. The patient was always at the center of the discussion, and several elements of the human experience were addressed in the subsequent questions including the physical, psychospiritual, sociocultural, and environmental factors (Kolcaba, Tilton, & Drouin, 2006). The APN was a very important part of this process as their personal feelings surrounding the experience of delivering bad news were also imperative to understanding the process. The results from the initial collection of stories formed the basis through which a consensus was identified, suggesting that there are four key skills that should be taught via four key methods. The four key skills are empathy, knowledge of data (treatment options and disease landscape), honesty, and knowing your patients' communication style. The four learning methods that the panelists recommended were practice, role play, observation, and use of a standardized tool. As a secondary result, the panelists identified several key themes that are involved in the delivery of bad news. These

themes included preparing for a rapid decline, working with a complex care team, the importance of communication within the care team, body language and positioning, evaluation of visual cues, and being well prepared. While developing the skill to deliver bad news is an individualized process, adapted from its inception based on the unique characteristics of each APN, these common themes may be useful as educators apply the consensus skills and methods to future educational interventions.

Consensus on Skills

The top nine skills identified by the panelists are elucidated in Table 1. The iterative survey process resulted in the skill of empathy being identified as the most important skill that an APN must develop. While some may believe that empathy is a skill that cannot be taught, a clinical perspective suggests that it is a method of interacting in a professional way with skill and competency (Mercer & Reynolds, 2002). An important differentiation is the separation of empathy from sympathy. The behavioral and cognitive aspects of empathy, commonly referred to as "emotional intelligence" help to make that differentiation. This was highlighted by several of the panelists as they described always starting an interaction by establishing what the patient did or would be able to understand. Maintaining that feedback loop with the patient, their caregivers, and advocates is a skill that can be taught in a variety of methods.

Honesty and self-awareness were identified as the second most important skill. The grouping of honesty and self-awareness as one skill was done by the panelists, but this combination is supported by the literature describing the moral courage required of nurses. In a concept analysis by Numminen, Repo, and Leino-Kilpo (2017), honesty was described as being able to question the behavior, both

of oneself and of colleagues, and having emotional intelligence. In order to question one's own behavior, self-awareness is critical. In the context of giving bad news, the panelists also consistently described honesty as being transparent through their stories.

A small majority (42%) of panelists agreed that the proper knowledge of data, scans, treatment options, and disease landscape was the third most important skill. The importance of content-specific knowledge was addressed in several ways by the panelists, but one put it most directly saying that, "I owe it to my patient to know what I am talking about if I am going to tell them that there is nothing else I can do and they are likely going to die of their disease." Developing and collecting data takes time and experience, but the skill that is most difficult to teach is understanding where the patient is in the disease trajectory and contextualizing the diagnostic results.

The fourth most important skill identified by the panelists was knowing your patient, their preferences, and their style of communication. While two-thirds of the APN panelists in this project work in outpatient settings where they may have a long-term relationship with a patient, a few panelists worked in inpatient settings and may regularly care for patients only for a few days at a time. The need to assess patient preferences and their preferred style of communication is something which could benefit from a long-term relationship. Interestingly, this skill appears to be one which many APN panelists have been able to adapt to their practice environment.

While there was consensus among the panelists on the top four skills, it is important to note that at least one panelist individually identified each individual skill as the most important. This demonstrates the value and utility of the Delphi

method as a tool for developing a consensus among a group of subject matter experts. However, it also highlights one of the limitations of the consensus tools.

Consensus on Learning Methods

The APN panelists proposed twelve methods for learning the skills necessary to delivery bad news. They were able to come to a consensus, though, on the top four methods that should be focused on as a starting point for educating APNs. A small majority, 42% of the panelists, felt that focused skills training such as role play would be the best way to teach the skills identified as necessary for delivering bad new to patients with cancer. The second most important method of learning was observation. It should be noted that 25% of panelists identified the use of a standardized tool, such as SPIKES, as the second most important method, although the consensus was that this would be the least important method. SPIKES is a six-step method that was developed in the late 1990's by Walter Baile (Baile et al., 2000) as a tool that could be used by medical oncologists to deliver bad news. At the time, its usefulness for medical students was evaluated as part of the original study. Baile et al. (2000) reported that the SPIKES tool in combination with role play and observation would have significant value for medical students. While not mentioned explicitly, one could assume that a student APN could utilize this tool as well.

Practice, in the form of role play and mentorship, was highlighted as the third most important method. Role play has multiple applications in advanced nursing practice and when combined with simulation can have a profound impact on learning (Vizeshfar, Dehghanrad, Magharei, & Sobhani, 2016). These results support an extensive emphasis on practice through role play and observation.

Limitations

While the results and consensus presented above may form a helpful basis for future educational interventions aimed at APNs who are new to oncology, there are several limitations to the study. The recruitment for the study was limited and the sample size of only twelve completed surveys limits the applicability across a larger population. Panelists for this study were recruited from the personal professional network of this author who is an oncology APN. An alternative recruitment approach would be to collaborate with an APN professional organization in an effort to find a larger and more diverse sample. A larger sample size would have also allowed for correlational statistics to be applied which could be helpful in tailoring educational interventions.

The participants in this study were skewed towards primarily working in academic medical centers. While most of these APNs identified their practice style as very independent, they operate in a care environment that comprised a multidisciplinary team. These teams often focus on one or a small group of malignancies. This specialization allows for increased communication, collaboration, and ease of access to specialty services. While it was outside the scope of this project with regard to evaluation, APNs who work in community settings may find it more difficult to access specialty services. This limited access could impact communication, development of specialty knowledge, and even limit or delay access to diagnostic services. A future study with a larger sample size should include more APNs who work in community settings, as it may be possible to tailor skills and an educational intervention that practice setting.

The survey tool itself was a limitation. This tool has not been validated and had to be developed for this specific project and as such has some deficiencies. As an example, the panelists were not directly asked how they were trained to deliver

bad news. Those panelists who may have had some formal training could have responded differently from those who did not.

This study was only able to recruit female APNs. However, while females do represent the majority of the APNs in the United States, male APNs are also present in cancer centers across the country and were, unfortunately, not represented in this study. It is estimated that 8% of nurse practitioners in the United States are male (Kaiser Family Foundation, 2019). Four male APNs were contacted for participation in this study, but they neglected to return the consent form despite two reminder emails. In as much as gender played a role in the outcome of some of the panelist stories, a future study should attempt to capture a more balanced population of male and female APNs.

Ethnically, this was a homogeneous group and not representative of the racial and ethnic diversity that make up the community of APNs in the United States. While the Delphi method was helpful as a guide for designing the layout of the study, the use of this method via electronic surveys was challenging. Panelists voted anonymously and were unable to interact with each other. If this method had been applied in a focus group or advisory board setting, a facilitator could have collected the information from panelists individually and, then, presented it back to the group for a discussion and agreement on the consensus. It is unknown how a group dynamic would influence these results. In this study, the panelists mostly came to small majority consensuses.

Conclusion

Overcoming the dichotomy of providing bad news in a compassionate and empathetic way that strengthens dialogue and enhances a caring environment is the ultimate challenge faced by APNs in the field of oncology. Developing the

skills required to deliver bad news is an individualized process and a topic which, historically, has received very little attention in academic programs, including advance practice nursing programs (Eid et al., 2009). Subsequently, most APNs learn how to deliver bad news by observing their attending medical oncologist, which explains the significant variation in this skill (Eid et al., 2009). Other advanced practice nurses have mastered this skill through their training and experience. This research aimed to establish a consensus among expert APNs in oncology on the skills required to delivery bad news, as well as the educational methods that can help students develop these skills. Using an established method of developing a consensus called the Delphi analysis, a novel patient-centered survey tool was developed that was designed to extract as much information as possible about this topic from the expert panel.

The expert panelists proposed a practice-based method focused on teaching empathy and self-awareness. This self-awareness, as an important part of the moral courage that nurses possess (Numminen et al., 2017), allows APNs to evaluate their behavior and make modifications in order to meet the needs of individual patients. Furthermore, they emphasized the importance of informed knowledge of the data and the patient. As the largest reported collection of data in the literature with 12 oncology APN panelists, these results provide a strong basis for the development of an educational platform that would be used to educate new APNs or those entering the field of medical oncology.

As a pilot project, the skills and learning methods identified by these expert panelists can form the basis for future research. While replicating this study with a larger and more diverse sample size would be important, it would also be reasonable to pair that research with the testing of different educational

interventions. An example of this could include getting direct feedback and input into a role-play model or methods of providing feedback to students in training.

Kolcaba's comfort theory is helpful in explaining the context within which bad news could be delivered to patients with advanced stages of cancer and their families as discussed above. More importantly, it addresses one of the key emotional (and safety) concerns that should be considered with patients after they receive bad news: How a patient and their family move past the bad news and feel a sense of comfort that may have been lost when the news was first given to them. It is more than simply understanding what their life would be like afterward or what they would talk about in the car ride on the way home. The APN, while providing comfort and carefully assessing the patients with advanced stages of cancer, can be helpful in identifying the issues that have disrupted any comfort (based on one of the four contextual frameworks discussed above) and develop a plan to help the patients address the bad news themselves. Success in this process not only fortifies the APN–patient relationship but starts the patient and family on a path where they are more engaged with the healthcare system.

REFERENCES

REFERENCES

American Society of Clinical Oncology. (2015). The state of cancer care in America,

    2015: A report by the American Society of Clinical Oncology. *Journal of*

    Oncology Practice.

Baile, W., Buckman, R., Lenzi, R., Glober, G., Beale, E., & Kudela, A. (2000). SPIKES

    – A Six-Step Protocol for Delivering Bad News: Application to the Patient with

    Cancer. *The Oncologist*, *5*(4), 302–11. DOI:10.1634/theoncologist.5-4-302.

Bengtsson, M. (2016). How to plan and perform a qualitative study using content

    analysis. *NursingPlus Open*, *2*, 8–14.

Bylund, C., Brown, R., Gueguen, J., Diamond, C., Bianculli, J., & Kissane, D. (2010).

    The implementation and assessment of a comprehensive communication skills

    training curriculum for oncologists. *Psycho-Oncology*, *19*, 583–93.

Eid, A., Petty, M., Hutchins, L., & Thompson, R. (2009). "Breaking Bad News":

    Standardized patient intervention improves communication skills for hematology-

    oncology fellows and advanced practice nurses. *Journal of Cancer Education*, *24*,

    154–59.

Elo, S., & Kyngas, H. (2007). The qualitative content analysis process. *Journal of*

    Advanced Nursing, 107–15.

Fujimori, M., Shirai, Y., Kubota, K., Katsumata, N., & Uchitomi, Y. (2014). Effect of

    communication skills training program for oncologists based on patient

    preferences for communication when receiving bad news: A randomized

    controlled trial. *Journal of Clinical Oncology*, *32*(20), 2166–172.

Hsu, C., & Sandford, B. (2007). The Delphi technique: Making sense of consensus. *Practical Assessment, Research & Evaluation*, *12*.

Keeney, S., Hasson, F., & McKenna, H. (2001). A critical review of the Delphi technique as a research methodology for nursing. *International Journal of Nursing Studies*, *38*, 195–200.

Kolcaba, K. (2001). Evolution of the Mid-Range Theory of comfort for outcomes research. *Nursing Outlook*, *49*(2), 86–92.

Kolcaba, K., Tilton, C., & Drouin, C. (2006). Comfort Theory: A unifying framework to enhance the practice environment. *The Journal of Nursing Administration*, *36*(11), 538–44.

Kolcaba, K. Y., & Kolcaba, R. J. (1991). An analysis of the concept of comfort. *Journal of Advanced Nursing*, *16*, 1301–1310.

Krinsky, R., Murillo, I., & Johnson, J. (2014). A practical application of Katarine Kolcaba's Comfort Theory to cardiac patients. *Applied Nursing Research*, *27*, 147–50.

Rounds, L., Zych, J., & Mallary, L. (2013). The consensus model for regulation of APRNs: Implications for nurse practitioners. *Journal of the American Association of Nurse Practitioners*, *25*(4), 180–85. DOI:10.1111/j.1745-7599.2013.00812.x

Ryan, P. (2009). Integrated theory of health behavior change: Background and intervention development. *Clinical Nurse Specialist*, *23*(3), 161–72.

Stadelmaier, N., Duguey-Cachet, O., Saada, Y., & Quintard, B. (2014). The basic documentation for psycho-oncology (PO-Bado): An innovative tool to combine

screening for psychological distress and patient support at cancer diagnosis. *Psycho-Oncology*, *23*, 307–14.

Stovall, M. (2016). Oncology communication skills training: Bringing science to the art of delivering bad news. *Journal of Advanced Practice Oncology*, *6*, 162–66.

Tanco, K., Rhondali, W., Perez-Cruz, P., Tanzi, S., Chisholm, G., Baile, W., ... Bruera, E. (2015). Patient perception of physician compassion after a more optimistic vs a less optimistic message: A randomized clinical trial. *Journal of the American Medical Association Oncology*, *1*(2), 176–83.

Vizeshfar, F., Dehghanrad, F., Magharei, M., & Sobhani, S. (2016). Effects of applying role playing approach on nursing students. *International Journal of Humanities and Cultural Studies*, 1772–781.

Volker, D., Kahn, D., & Penticuff, J. (2004). Patient control and end-of-life care part I: The advanced practice nurse perspective. *Oncology Nursing Forum*, *31*, 945–53.

Whiting, D., & Cole, E. (2016). Developing a trauma care syllabus for intensive care nurses in the United Kingdom: A Delphi study. *Intensive Care and Critical Care Nursing*, *36*, 49–57.

Wilkinson, S., Perry, R., Blanchard, K., & Linsell, L. (2008). Effectiveness of a three-day communication skills course in changing nurses' communication skills with cancer/palliative care patients: A randomised controlled trial. *Palliative Medicine*, *22*, 365–75.

APPENDICES

APPENDIX A: PANELIST SURVEY – ROUND #1

Understanding the Skills Required to Deliver Bad News to Patients with Cancer

Q3. What is your year of birth?

_____

✳

Q11. What is your ZIP code?

_____

Q5 What is the highest level of education you have completed or the highest degree you have received?

○ BSN (1)

○ MSN (2)

○ DNP (3)

○ PhD (4)

○ DNSc (5)

○ Ed.D (6)

○ Other (7)

Q7 Choose one or more options based on your individual racial identity:

☐ White (1)

☐ Black or African American (2)

☐ American Indian or Alaska Native (3)

☐ Asian (4)

☐ Native Hawaiian or Pacific Islander (5)

☐ Other (6) _____

Q9 What is your sex?

○ Male (1)

○ Female (2)

○ Gender Neutral (3)

Q13 Which statement best describes your current employment status?

○ Working (paid employee) (1)

○ Working (self-employed) (2)

○ Not working (temporary layoff from a job) (3)

○ Not working (looking for work) (4)

○ Not working (retired) (5)

○ Not working (disabled) (6)

○ Not working (other) (7) _____

○ Prefer not to answer (8)

Q15 Are you currently working as a Nurse Practitioner in Oncology?

○ Yes (1)

○ No (2)

Q16 How long have you been working as a Nurse Practitioner in Oncology?

○ Less than 5 years (1)

○ 5–10 years (2)

○ 10–15 years (3)

○ 15–20 years (4)

○ 20+ years (5)

Q17 Please select the practice setting that most accurately describes where you primarily work.

○ Academic Medical Center – Inpatient (1)

○ Academic Medical Center – Outpatient (2)

○ Community Hospital – Inpatient (3)

○ Community Hospital – Outpatient (4)

○ Private Practice/Non-hospital based clinic (5)

○ Other (6)

Q18 How would describe your primary practice style?

○ Very independent – sees most patients independently (1)

○ Somewhat independent – have some clinics alone, some joint clinics with attending MD (2)

○ Mostly joint visits with attending MD (3)

○ Other (4) _____

End of Block: Demographic and Background Questions

Start of Block: Story about delivering bad news

Q20 Please describe a recent situation when you had to give bad news to a patient with cancer and where you felt comfortable delivering the news? (Please de-identify your story).

_____

_____

_____

_____

_____

Q21 Reflecting on the experience you just wrote about, what were some of the visual cues that your patient exhibited?

_____

_____

_____

_____

_____

Q14 Reflecting on the experience you just wrote about, what emotions did your patient exhibit?

_____

_____

_____

_____

_____

Q15 Reflecting on the experience you just wrote about, how well prepared were you to deliver the bad news?

○ Extremely well-prepared (1)

○ Very well-prepared (2)

○ Moderately well-prepared (3)

○ Slightly well-prepared (4)

○ Not well-prepared at all (5)

Q16 Reflecting on the experience you just wrote about, what specifically did you do to prepare for the visit?

_____

_____

_____

_____

_____

Q17 Reflecting on the experience you just wrote about, what was your patient's primary concern after they heard the news?

_____

_____

_____

_____

_____

Q18 Reflecting on the experience you just wrote about, what was your relationship like with your patient and their family after the visit?

_____

_____

_____

_____

_____

Q19 Reflecting on the experience you just wrote about, was the patient alone or did they have family members present? Please describe.

_____

_____

_____

_____

_____

- -

Q20 Reflecting on the experience you just wrote about, how did the spouse or family member react to the news?

_____

_____

_____

_____

_____

End of Block: Story about delivering bad news

Start of Block: General Questions about Delivering Bad News

Q21 Is therapeutic touch a part of your approach in delivering bad news?

○ Definitely yes (1)

○ Probably yes (2)

○ Might or might not (3)

○ Probably not (4)

○ Definitely not (5)

Q22 What feelings do you experience after delivering bad news?

_____

_____

_____

_____

_____

Q23 Think about when you were beginning your career and the process of delivering bad news that you used. Describe what an early experience of delivering bad news was like.

_____

_____

_____

_____

_____

Q24 Thinking about that early experience, what was one key lesson you took away from that?

_____

_____

_____

_____

_____

Q25 How did your practice of giving bad news change over time?

_____

_____

_____

_____

_____

Q26 If you had to list the top three skills that a new advanced practice nurse in oncology had to learn in order to successfully deliver bad news to patients with cancer, what would they be?

○ Skill #1 (1) _____

○ Skill #2 (2) _____

○ Skill #3 (3) _____

Q27 What do you think is the best way to learn how to give bad news?

_____

_____

_____

_____

_____

End of Block: General Questions about Delivering Bad News

APPENDIX A: PANELIST SURVEY – ROUND #2

Round Two - Developing a Consensus

Q1 In the first survey you were asked to list the top 3 skills that a new advanced practice nurse in oncology had to learn in order to successfully deliver bad news to patients with cancer.

Your responses have been synthesized into the top 9 skills (out of 36) identified by the respondents.

Please rank the following skills in order of importance. You can "drag and drop" the skills in the order of importance- 1 being most important, 9 being the least important.

_____ Empathy (1)

_____ Knowledge of data, scans, treatment options, and disease landscape. (2)

_____ Honesty (3)

_____ Self-awareness (4)

_____ Active Listening (5)

_____ Setting the right scene (who should be present, room setup) (6)

_____ Know your patient, their preferences, and their style of communication. (7)

_____ Self-preservation (ability to debrief with team to relieve pressure after meeting) (8)

_____ Take your time and be thorough (do not rush) (9)

Q2 In the first survey you were asked what you think is the best way to learn about how to give bad news.

Your responses have been synthesized into the top 3 (out of 12) identified by the respondents.

Please rank the following skills.
_____ Practice (4)
_____ Focused Skills Training- Role Play (5)
_____ Observation - Have a good mentor and watch them deliver bad news. (6)
_____ Use a standardized tool such as SPIKES. (7)

End of Block: Ranking the recommendations

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