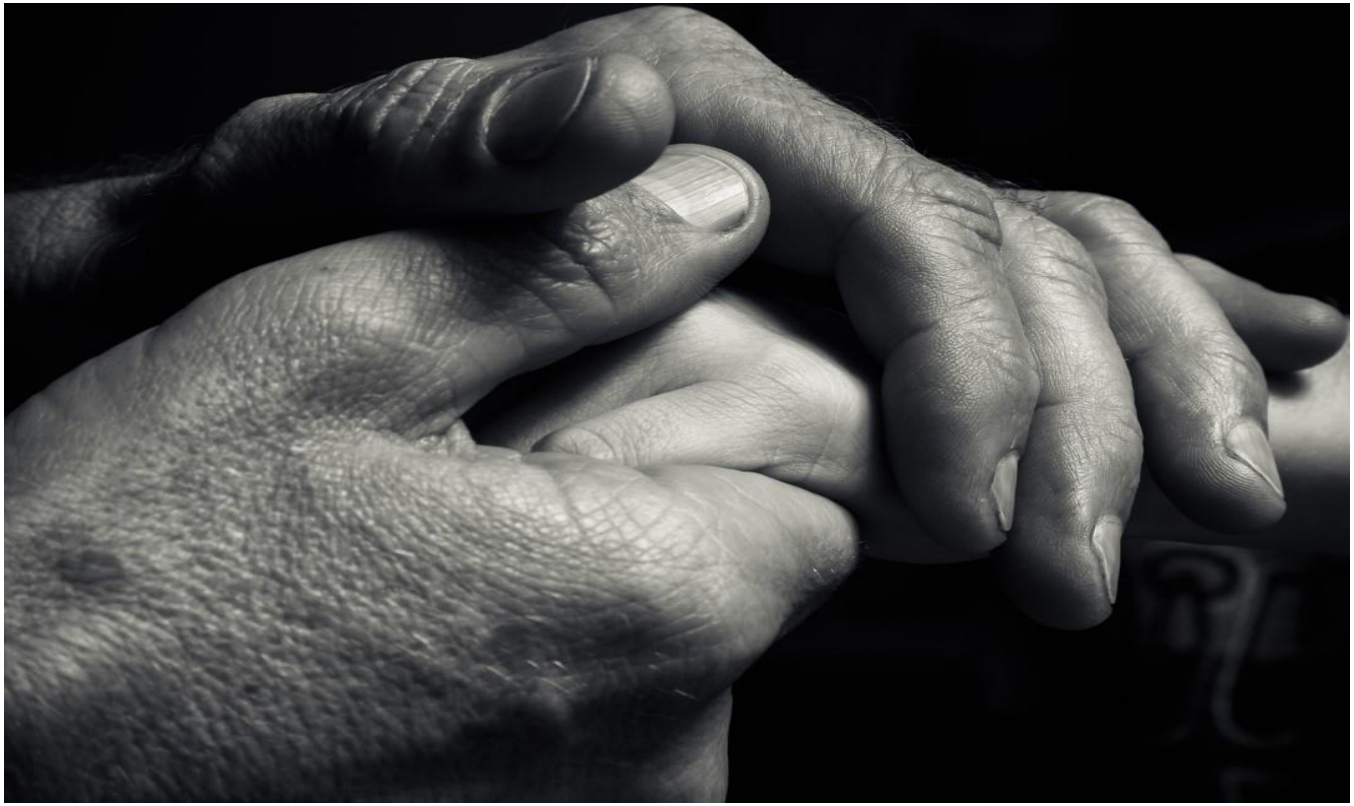
Liverpool University Hospitals
NHS Foundation Trust

Managing difficult conversations
PCUK – March 2026



Phil Whelan
Pancreatic Nurse Consultant
Liverpool University Hospital Foundation Trust
(Philip.Whelan@rlbuht.nhs.uk)

- **Delivering bad news**
  - What the textbooks say - "I am not an expert"
  - Models of communication and breaking bad news

- **Delivering bad news - Pancreatic Cancer**
  - Outpatient Nurse led models of care in Liverpool – respect all roles and units are different
  - Breaking bad news in my role..
    - At diagnosis
      - Surgery, follow up and potential recurrence
      - Inoperable and metastatic disease
- **Getting in right – Tips and hints**

- **Case study's - 1. How bad communication can have lasting effects 2. Multiple times " bad news" given**

- **Key Messages**
  - Empathy ***"walking in someone else's shoes"***
  - Self-care is important

An expert in breaking bad news is not someone who gets it right every time – he or she is merely someone who gets it wrong less often, and who is less flustered when things do not go smoothly.

R Buckman

SPIKES Model

The SPIKES protocol for breaking bad news has four objectives:

- Gathering information from the patient
- Transmitting the medical information
- Providing support to the patient
- Eliciting patient's collaboration in developing a strategy or treatment for the future.

S – Setting

- Arrange for some privacy – Very important , easier in outpatients than inpatient review
- Involve significant others – clarify who is present in room
- Sit down at eye level with patient
- Make connection and establish rapport with the patient
- Manage time constraints and interruptions (I give my phone to health care assistant in clinic)

- Accept denial but do not confront at this stage.
  - *"I've not been told anything. Oh yeah I was told that"*

P – Perception of condition/seriousness

- Determine what the patient knows about the medical condition or what they suspect
  - *"What do you understand about your condition?"*
- Listen to the answer and the words patient uses / level of comprehension

I – Invitation from the patient to give information

- Ask patient if they know the details of the medical condition / treatment
  - *“what have you been told so far?”, “what brought you to clinic today? ”*
- Accept patient’s right not to know
- Offer to answer questions later if they wish
- Recognise that the patient and family may be different in their desire for information.

K – Knowledge: giving medical facts

- Use language intelligible to patient and check they understand what you have said
- Consider educational level, socio-cultural background, current emotional state
- Give information in small chunks
- Respond to the patient’s reactions as they occur
- Give any positive aspects first
- Give facts accurately about treatment options, prognosis

E - Explore emotions and sympathise

Liverpool University Hospitals NHS Foundation Trust

- Prepare to give an empathetic response:
  1. Identify emotion expressed by the patient (sadness, silence, shock etc.)
  2. Identify cause/source of emotion
  3. Give the patient time express their feelings, then respond in a way that demonstrates you have recognised
- Appropriate use of touch – if invited

S – Strategy and summary

- Close the consultation
- Ask whether they want to clarify something else
- Offer plan moving forward – written or verbal / HNA

Baile, W. et al. SPIKES – A six step protocol for delivering bad news: application to the patient with cancer. The Oncologist 2000; 5:302-311.
Buckman, R. Breaking bad news: the S-P-I-K-E-S strategy. Community Oncology 2005; 2: 183-142.

Nurse led models of care in Liverpool

Liverpool University Hospitals NHS Foundation Trust

- **Triage of all MDT cases / Inpatient reviews / AE review**
  - Normally flagged via direct e ref – Part of new extended role– CT showing something
  - Aid to referring team to plan patient care and pathway – surgery, stent etc
  - If more palliative diagnosis - planned meeting with patient / family post MDT /pre MDT
  - Education with ward staff re pathways and promotion of service and role

- **Surgery – seen usually as outpatient**
  - All patients seen in Liverpool will have CNS / NC present at initial meeting with surgeon – Patients will often have been told potential diagnosis
  - CNS / NC will act as “key worker” and guide though all management
  - Supportive role to patient and family

- **Post operative surgical follow up**
  - Discussing post operative histology results – CNS / NC led
  - Nurse reviews with post op patients discharged from oncology after adjuvant therapy completed
  - Continued surveillance with structured reviews
  - Maintaining “hope”
  - Patient education key - “red flag signs”
  - Linking with support group - very important
  - ***“fear of recurrence”***

- **Recurrence**

  - As patients followed up by the surgical team usually patients remains well known to CNS / NC team
  - CT/ PETs due to symptoms / bloods
    - Opportunity for “warning shots”
  - CNS / NC can track scan results and push for urgency of results – can help reduce stress and anxiety BUT aware this will always be present
  - Discussion over results (scan +/- MDT) in an environment suitable for these discussions and with a professional who is known to the patient and family
  - Palliative treatment options
  - Link with palliative care /enhanced supportive care

Non surgical patient / palliative optimisation clinic

- A twice weekly clinic (on two different sites across the city)
- Designed to see newly diagnosed inoperable patients to discuss MDT decisions, break bad news, discuss diagnosis & prognosis and ongoing care / treatment

  - Patients seen direct from MDT – Vast majority to contact with clinician re results so true “breaking bad news”
  - Carefully designed letters / texts and support from 2-week team re phone invites – meeting with admin team to plan

Non surgical patient / palliative optimisation clinic

- Quiet environment away from “bustle” of normal clinic
  - Not linked with surgical clinic – less confusion for patients
- Handpicked HCAs to help !

- Nurse consultant led with dietetics support (when appropriate or triage / contact soon after fore review)

- Improved links with oncology team & access to clinical trials and with community palliative care services- vital

Getting it right …

Liverpool University Hospitals NHS Foundation Trust

- **Prepare**
  - Read CTs , notes , MDT in detail prior to review so can focus all attention on patient/ family and their news
  - Try not to have multiple cases of “bad news” back to back – I am AWFUL at this !
- **Environment**
  - Pagers , phones off (if you can)
  - Talk to staff outside room – minimise background noise – difficult in AE
  - Use pictures / images on computer – if this is what patient wants
  - Water and tissues to hand - correct number of chairs – simple things

Getting it right …

- **Listen**
  - Pick up on patient cues , language , non verbal communication , open questions
  - What does your patient want to know ?
  - What are you and/ or family comfortable discussing ? Important with prognosis discussions
  - What is important to you ?

- **Symptom review**
  - Often discussion will involve symptom review / new medication plan / referrals on – Leave time for this

- **Reflect**
  - End conversation with a chance to re visit discussion in a succinct way

Liverpool University Hospitals
NHS Foundation Trust

Amy's story

- Misdiagnosed – told "its all in your head" for worrying about cancer

- Inoperable Pancreatic Cancer – April 2017 – Finally felt listened to but whole world fell apart as lead to believe was for surgery

- Oncology tx – Led to resection (PPPD and PV resection) in July 2017

- Fear of recurrence - "its always in my head mate"

"empathy is the art of stepping imaginatively into the shoes of another person, understanding their feelings and perspectives, and using that understanding to guide your actions"

Roman Krznaric

Key messages

Liverpool University Hospitals NHS Foundation Trust

- **There is no "textbook" way to break bad news**
- **You will make mistakes**
  - Learn from them
  - Reflect on them
  - Be and "rock and a sponge"
- **Walk in someone else's shoes -** keeps you grounded
- **No matter how experienced or skilled it may not be enough**
  - Prepare for negative comments – even complaints – what you do may not be good enough !
  - Often "You're the voice of the MDT" - What if that's wrong ?
- **Look after yourself**
  - Difficult conversations and breaking bad news are huge part of the extending nursing role , yet they take their toll !
  - Don't take everything home with you – Share your thoughts and feelings
  - Find a mentor

Finally ..a big “ **Thankyou**”

Liverpool University Hospitals NHS Foundation Trust

For…

- Your hard work…
- Your “turning up”
- Your compassion and your passion
- Your skills
- Your knowledge

- And despite what’s going on with the NHS - for doing it …