All nurses know what a DNR is. But how about DDN? My guess is that only a minority of nurses would have encountered this set of alphabet letters. Both DNR and DDN are TLAs. A TLA is a three-letter acronym or three-letter abbreviation. TLAs have categories, such as politicians (FDR), airports (LAX), countries (USA), clinical shorthand (OOB), and even the more recent brief communications, such as LOL or OMG.

Please stay with me. I think you’ll find DDN very interesting. I first encountered DDN in a manuscript submitted by Michelle Cleary, from New South Wales, Australia. She and her co-authors had had an earlier article, “Delivering Difficult News in Psychiatric Settings,” published in the Harvard Review of Psychiatry, (Cleary, Hunt, & Horsfall, 2009). They pointed out that breaking bad news is more commonly written about in nonpsychiatric areas, such as oncology or trauma settings. The delivering difficult news (DDN, also called BBN—breaking bad news—in some parts of the world) literature in psychiatry, until their article, focused on dementia rather than other diagnoses.

Cleary et al. (2009) considered bad news from the viewpoint of both the conveyor and the receiver. Referring to earlier articles about bad news, including one that addresses how medical students should be taught to manage this delivery, they state: “The way in which bad news is conveyed can affect the receiver’s physical and emotional health, attitude to recovery, willingness to adhere to a medical regimen, relationships with clinicians, and treatment satisfaction” (p. 316). In other words, the method is as important as the message.

NEW LANGUAGE, OLD GUIDELINES

Reading both this earlier article and Cleary, Hunt, Escott, and Walter’s recent submissions to the Journal of Psychosocial Nursing and Mental Health Services, published in this month’s issue, it occurred to me that what was being described and suggested about delivering difficult news well really should be principles practiced in any therapeutic relationship. In fact, although the language sounds new, the principles behind them are old. Reserving the suggested good practices only for bad news strikes me as rather strange. It’s similar to taking out the good china only for special occasions, or minding one’s words only when third parties are listening.

The notion that disclosure of diagnoses and treatment options should be open and honest has been reported in many places. In 1983, the World Psychiatric Association recommended that patients be told their diagnoses, treatment choices, and likely outcomes, and that this information should be delivered in a respectful and considerate manner (Mitchell, 2007). Mitchell (2007) also mentioned the London-based National Institute of Health and Clinical Excellence (NICE), which reiterated the same principles regarding clear information about treatments and services.

SPIKES

While much discussion about clear communication appears in the literature, Cleary et al., in their articles in this issue, state that the leaders in producing effective guidelines are Buckman (2002) and Baile et al. (2000). To help clinicians recall the sequential, stepwise guidelines, Baile et al. (2000) constructed SPIKES. The six steps, summarized, are:

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OMG

DNR? DDN? TLA?
Set up the interview.
Assess patients’ Perception of their medical circumstances.
Obtain patients’ Invitation to receive the information.
Give the requisite Knowledge.
Respond empathically to patients’ Emotions.
Summarize the treatment processes.

BEEN THERE, DONE THAT
Psychiatric nurses who have read and studied with Hildegard E. Peplau will immediately see the similarities to her clinical teaching. She required her master’s students to read all of Harry Stack Sullivan’s work, beginning with The Psychiatric Interview (Sullivan, 1954). Step 3 of the SPIKES guidelines was described by Peplau as setting the contract for what would happen between the patient and the nurse. The nurse learned to be clear about what he or she had to offer, beginning with when the nurse would be with the patient and how long the nurse would stay. For Peplau, Step 4, “giving the requisite knowledge” would be embodied in how the nurse guided the patient to tell his or her story or personal details, giving cues to help the patient fill in details. The essence of this working stage was seeing the past in a new light, or using a different set of lenses to understand the past and plan for the future.

Although Peplau rarely focused on emotions, per se, she did acknowledge them. In fact, her earlier teachings on loneliness and helplessness demonstrated that empathy was feeling in oneself what was felt in others (Peplau, 1955). For example, the tears in helplessness were seen as the result of not being able to grapple—in words—with the news of extreme joy or sadness. Being overwhelmed is what happens when unanticipated or unexpected news is heard. Another way to think of this is to view these experiences as miniature versions of hearing bad or difficult news.

Peplau retired nearly 40 years ago. Since then, patients are now acknowledged to have a legal and moral right to receive correct, comprehensible, timely, and relevant information. In addition, they have the right to refuse treatment, including medication protocols. And only after a judicial process may they be hospitalized against their wishes.

DDN PRINCIPLES SHOULD BE “NORMAL ORDER”
Delivering difficult news may be seen as just the beginning of a long and complex process. The principles outlined above need to be modified, depending on the age of the patient, cultural factors, their home and work environments, and available funds for care. More important, however, the principles should be practiced as the “normal order” for interactions between patients and nurses. The process should not be “special,” but rather “regular.”

REFERENCES