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Original Article

Survey on perceptions and skills amongst postgraduate residents regarding breaking bad news at teaching hospitals in Peshawar, Pakistan

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Abstract

Objective: To assess the perception, skills and comfort level of postgraduate residents with respect to breaking bad news.

Methods: Five workshops were conducted on communication skills, including the task of breaking bad news, at three teaching hospitals of Peshawar, Pakistan. Teaching methods included interactive lectures, video presentations, role play and small group discussions. Pre- and post-workshop data was collected from all the 97 participants to assess their previous training, comfort level and perceptions regarding the subject and any improvement after attending the workshop.

Results: Of the total participants, 92 (95%) residents had not received any training in communication skills at the undergraduate level. Only 64 (66%) residents had witnessed bad news being broken by a consultant. Before the workshop, 83 (85%) residents felt either not comfortable or somewhat comfortable while breaking bad news compared to 36% post-workshop ($p < 0.0000$). Besides, 64 (66%) residents reported breaking bad news to be extremely stressful or very stressful before the workshop versus 25% post-workshop ($p < 0.0000$). Before the workshop, 18 (19%) residents said they would withhold the information from the patient on family's insistence despite the patient's wish to be informed, compared to 6% post-workshop ($p < 0.007$). Regarding the utility of the workshop, 91 (94%) residents said it had changed their perceptions to a major extent, while 92 (95%) residents rated the workshop as extremely useful or very useful.

Conclusion: Formal structured training in breaking bad news is lacking both at undergraduate and postgraduate levels in Pakistan. Structured training programmes for residents can do the task effectively.

Keywords: Breaking bad news, Communication skills, SPIKES, Palliative care, Pakistan (JPMA 62: 585; 2012).

Introduction

Breaking bad news (BBN) to patients and their relatives is a complex and stressful task. This important communication skill is required in almost all branches of medicine, including oncology, intensive care units, paediatrics, gynaecology and obstetrics, orthopaedics, ophthalmology and many other disciplines. Therefore, almost all physicians and surgeons will have to deal with BBN multiple times in their professional lives. However, even in the developed countries, almost half of the doctors at consultant level reported not to have received any formal training in the task of breaking bad news to patients.[1] Literature from countries, including the US and the UK, has stressed upon the need of structured training of medical students and residents in BBN.[1,2] In the last decade, teaching and assessment of communication skills, including BBN, has become an essential part of undergraduate and postgraduate medical training in many countries.[3,4]

The situation regarding training in BBN is far from satisfactory in most of the developing countries. A survey conducted in a medical school in Iran reported lack of training in communication skills at the undergraduate level. This resulted in unsatisfactory performance of interns, which, in turn, negatively affected patient satisfaction.[5] In Turkey, medical students who did not receive any formal structured training in BBN reported a great deal of anxiety and stress when confronted with such situations.[6] Studies conducted in India also showed that over 50% oncologists did not have any training in BBN and most of these oncologists requested for formal training.[7] Medical students in India also expressed their desire that structured formal training in BBN should be made part of their curriculum.[8]

In Pakistan, too, the situation regarding BBN is far from satisfactory. Although Pakistan Medical and Dental Council (PMDC) has included communication skills in its design objectives in undergraduate curriculum, yet most of the young trainees are unaware of the significance of being able to handle this complex task. This is because little or no

emphasis is laid on formal teaching of this essential skill in most of the medical institutions in Pakistan. A study conducted amongst doctors from various parts of Pakistan involved in palliative care reported that 40% of the doctors could not break bad news properly and showed willingness to have formal training in BBN.[9]

Fortunately, many studies have shown that the art of breaking bad news can be taught and learnt and proper training in this skill will fill the gaps in residents' knowledge about BBN.[10,11] Many protocols have been published with almost similar sequence of events but the most commonly used protocol for BBN is the six-step SPIKES protocol.[12,13]

We conducted this study in order to assess the perceptions, skills and comfort level of postgraduate residents regarding BBN and whether these can be improved with the help of formal structured training.

Methods

This was a simple survey using quasi-experimental (pre- /post-intervention) study design.[14] We conducted five workshops on communication skills at all the three Peshawar-based public-sector postgraduate teaching hospitals affiliated with the Postgraduate Medical Institute (PGMI) — Lady Reading Hospital, Khyber Teaching Hospital and Hayatabad Medical Complex, Peshawar. These workshops were held between August 2009 and January 2010 with the aim of improving communication skills with special emphasis on BBN among postgraduate residents.

These workshops were open to residents of all years and all 24 specialties offered by the PGMI. Between 18-25 residents participated in each workshop. A total of five workshops were conducted during the study period. Participation in these workshops was voluntary. One-day session was held on communication skills using the philosophy of adult learning methods.

An interactive overview of the topic was presented by the facilitators with clear learning objectives defined at the start. The commonly used 6-point SPIKES protocol (Box) for BBN was discussed in detail point by point. Video presentations were made over multimedia showing bad news being broken to patients. These sessions were followed by open discussion, critique and feedback from the participants and suggestions by them as to how these can be further improved.

After the interactive overview lecture and video presentations, participants were broken into five random groups. Each group was given a case scenario in which bad news had to be broken under different circumstances. Each presentation was followed by critique, feedback and detailed discussion by the larger group. At the end of the final discussion, residents were encouraged to discuss their own emotional experiences while dealing with patients who had to be broken bad news to, and how they will deal with them after the workshop.

Pre-workshop data-collection tool was distributed among all the residents. Questions were asked regarding any previous training in communication skills, whether they had observed bad news being broken by a senior, how stressful they thought BBN was to them before this workshop, how confident they felt about BBN before the start of the workshop, and how many times they had broken bad news to patients or their families. Post-workshop data-collection tool was distributed among the participants after the conclusion of the workshop. Questions were asked regarding the effectiveness of the workshop, whether attending the workshop had made them feel more confident than before to properly break bad news, whether the workshop will help reduce their stress levels in future, whether the workshop had changed their perceptions regarding BBN. Categorical questions were used in these data-collection tools to quantify perceptions and attitudes and any changes in them.

Anonymous workshop evaluation proformas were also distributed among the residents after the completion of workshop for overall evaluation of the different aspects of the workshop.

The sample size for the study, which was approved by the Institutional Research and Ethics Board (IREB) of PGMI, was calculated using a Confidence Interval of 95% (precision level 0.05), error margin of 5% and power of 80%. Convenience sampling was used in the study. To test the significance of the difference before and after the workshop, Chi-square test was applied (2x2 contingency table) and p-value was calculated. Level of significance was chosen at 0.05.

Results

A total of 97 residents belonging to different specialties and years of training participated in these five workshops (Table-1). Residents from 19 different specialties attended the workshops. Data collection tools were administered to and collected from all the 97 residents.

Only 5/97 (5.15%) residents reported to have received formal training in communication skills as an undergraduate medical student, while 64 (66%) had witnessed bad news being broken by a senior consultant. Amongst the 97 participants, 54 (56%) had attended formal training workshop in communications skills offered by the College of Physicians and Surgeons of Pakistan (CPSP) after starting their residency. Interestingly, only 5/54 (09%) residents who had attended the CPSP workshop on communication skills could recall the SPIKES protocol, but 32 (59%) of them reported to feel comfortable breaking bad news after attending the CPSP workshop.

Among the residents, 83 (85%) reported that they felt

Table-1: Characteristics of the participating residents.

Characteristic	
Age:	Median: 30.4 years (IQR 3)
Sex:	
Male	64 (66%)
Female	33 (34%)
Year of residency training:	
First year	28 (29%)
Second year	34 (35%)
Third year	17 (18%)
Fourth year	13 (13%)
Fifth year	05 (5%)
Fields of specialization of participating residents:	
Obs & Gynae	24 (24.7%)
Ophthalmology	10 (10.3%)
General Surgery	08 (8.3%)
Pulmonology	07 (7.3%)
Gastroenterology	06 (6.2%)
General Medicine	06 (6.2%)
Paediatric medicine	05 (5.2%)
ENT	05 (5.2%)
Plastic Surgery	04 (4.1%)
Haematology	04 (4.1%)
Orthopaedic surgery	03 (3.1%)
Neurosurgery	03 (3.1%)
Diagnostic radiology	03 (3.1%)
Cardiology	03 (3.1%)
Dermatology	02 (2%)
Nephrology	01 (1%)
Urology	01 (1%)
Psychiatry	01 (1%)
Community medicine	01 (1%)

Table-2: Number of times the participants had broken bad news to patients in the preceding 12 months.

Year of residency	Number of times bad news was broken		
	Never	1-6 times	7 or more times
1st year residents	5 (5.2%)	15 (15.4%)	8 (8.3%)
2nd year residents	3 (3.1%)	18 (18.6%)	13 (13.4%)
3rd year residents	2 (2%)	10 (10.3%)	5 (5.2%)
4th year residents	2 (2%)	1 (1%)	10 (10.3%)
5th year residents	0 (0%)	5 (5.2%)	0 (0%)

either not comfortable at all or only somewhat comfortable while breaking bad news to a patient alone. Besides, 64 (66%) were of the view that breaking bad news to patients was extremely stressful or very stressful for them. The number of times each resident had broken bad news in the preceding 12 months was also noted (Table-2).

Residents were asked if a mentally stable patient diagnosed with cancer requests to disclose the diagnosis and other medical information but the relatives prefer otherwise, what they will do. Of the total, 41 (42%) said that they will disclose the diagnosis and all the information to the patient; 38 (39%) said they will talk to the patient first regarding how much information he or she wants and then disclose

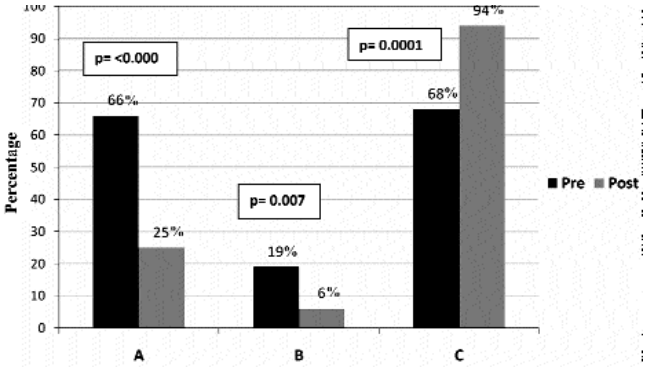

Figure: Summary of Pre- and Post-Workshop Comparison: A= stress levels during breaking bad news; B= will you withhold information from patient on family's request; C= importance of shared decision making (SDM). P-value was calculated using chi-square test.

BOX: The SPIKES Protocol:

S	Setting up the interview
P	Assessment of patient's Perceptions
I	Obtaining Invitation from the patient
K	Knowledge and information transfer to patient
E	Empathy and Emotional support for the patient
S	Strategy for the future and Summarising.

accordingly; while 18 (19%) residents said that they will withhold the diagnosis and information on the relative's request.

Residents were asked how often patients were involved in treatment planning in their units. To this, 66 (68%) residents said that shared decision-making (SDM) was practised to a major extent in their wards.

After the completion of the workshop, 62 (64%) residents reported that they will feel extremely comfortable or very comfortable breaking bad news after having attended the workshop compared to 15% before the workshop ($p < 0.0001$). To another question, 73 (75%) residents reported that after their stress level will either be reduced to a great extent or that they will feel no stress at all in a BBN scenario compared to 34% before the workshop ($p< 0.0001$).

When asked whether attending this workshop had changed their perception about BBN, 91 (94%) residents said it had done so either to a major or to some extent. Only 6 (6.18%) residents reported no change or some minor change in their perceptions. When asked how they will respond now if a patient with cancer asked about the diagnosis and medical information while his relatives forbid them to do so, 57 (59%) said they will disclose the news to the patient, 34 (35%) said they will talk to the patient regarding how much information he or she wants, while only 06 (6.18%) said they will still withhold information from the patient despite his/her wishes.

This change in perception was highly significant compared to that before the workshop (19% pre-workshop vs 6% post-workshop; $p < 0.007$).

When asked how important the residents felt SDM was, 91 (94%) said it was very important compared to 68% before the workshop ($p < 0.0001$) (Figure).

The workshops were rated as extremely useful or very useful by 92 (95%) residents, while 94 (97%) responded positively when asked if they will recommend the workshop to other residents. In their comments, most residents appreciated the effort of conducting workshops such an important topic, and recommended increase in the workshop duration, making it mandatory for all residents and holding such workshops frequently so that they may get an opportunity to refresh their knowledge later in their training.

Discussion

Full disclosure and SDM has replaced the paternalistic model of patient-doctor relationship in the West. However, in many developing countries, the transformation from paternalism to patient autonomy has not taken place yet. To complicate matters further, family's intervention in disclosing bad news to patients is also very frequent in developing countries, including Pakistan, thereby affecting patient autonomy.[15] Insufficient knowledge of relatives regarding cancer has been cited as one main reason for them to insist that news about diagnosis should be withheld from the patients.[16] Other reasons include cultural barriers, attitude of the doctors and lack of formal training to doctors.[15,17,18] This attitude of doctors and relatives is in contrast to patient's wishes a vast majority of whom, according to available literature, want full disclosure.[19-21] In a study conducted in Pakistan regarding patients' perceptions and expectations about BBN, 40% of the patients were of the view that they wished for full disclosure and that this was the fundamental right of patients.[22] Even children who were given relevant information about their diagnosis and treatment plan at the start of the treatment showed lesser amount of anxiety and depression.[23] Therefore, it is essential for all doctors to be prepared to break the bad news to those patients who wish to have all the information.

In our study, we found that 95% of our participants had not received any formal training in BBN during their time at medical schools. Even more alarming was the fact that less than 10% of those who had attended a communication skills workshop earlier could recall the SPIKES protocol which is commonly used for BBN. Besides, 85 percent of our residents expressed low comfort level for BBN while two-thirds considered this as either very stressful of extremely stressful. Despite their lack of training and low comfort level with BBN, 88% of the participants had broken bad news to patients on their own while almost a quarter of our residents reported to have done this over 10 times in the preceding 12 months. This fact further emphasizes the importance of providing structured training programme for residents in essential communication skills at regular intervals. Similar stress and anxiety have been reported in interns in other studies when they were exposed to BBN without any formal training.[6,24] When these interns were trained in communication skills, their confidence levels also showed an increase.[24] These studies along with our current study clearly showed the important role of structured training in communication skills in increasing the confidence level of trainees and reducing their stress and anxiety levels. Better communication skills also result in increased patient satisfaction and improved doctor-patient relationship.

Our study showed that doctors at postgraduate level in Pakistan are not aware of the intricacies involved in the process of BBN. However, a strong and positive message coming out of the study was that the residents were willing to undergo training in such soft skills and showed a remarkable improvement in their perceptions and skills after attending the structured programmes. Our results are consistent with other studies that have shown a significant improvement in knowledge, skill and attitude of doctors in communication skills after attending training programmes.[10,11,24] Other studies have also shown that health professionals from primary healthcare workers to consultants at teaching hospitals have expressed a desire to have training programmes in communication skills.[1,25] These studies and our results are encouraging for arranging structured training programmes for our doctors throughout their training, whether at undergraduate or postgraduate levels.

Our study limitations include grouping of options such as 'not comfortable at all' and 'only somewhat comfortable' together into one category when comparing with 'very comfortable.' This may result in misrepresentation of the participants' opinion to some extent. A larger sample from the whole province, both public and private-sector hospitals, and preferably from various institutions across the country, will further strengthen the findings. A follow-up survey six to twelve months after the workshop will be helpful in finding whether the knowledge and skills learnt were retained in the long run and whether they were being practised as taught.

Conclusion

Training of communication skills, including BBN, shall be made an essential component of medical education with frequent refresher courses for the postgraduates.

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