Breaking bad news skill of postgraduate residents of tertiary care hospital of Lahore, Pakistan: A cross-sectional survey

Muhammad Zeeshan Sarwar,[1] Fakeha Rehman,[2] Syeda Mehak Fatima,[3] Muhammad Suhail,[4] Syed Asghar Naqi[5]

Abstract

Objective: To evaluate the skill of postgraduate residents in breaking bad news to the patients in a tertiary care hospital.

Methods: The cross-sectional study was conducted at King Edward Medical university, Lahore, Pakistan, from January to April 2016, and comprised postgraduate residents of different specialties at Mayo Hospital, Lahore. The subjects were examined in terms of their personal experience in breaking bad news to the patients by means of a specifically-designed questionnaire based on six-step protocol of Setting, Perception, Invitation, Knowledge, Empathy and Summarising model. Data was qualitatively and quantitatively analysed using SPSS 22.

Results: Of the 200 respondents, 141(70.5%) were males and 59(29.5%) were females. Overall mean age of the sample was 23 ± 2.55years. Of the total, 94(47%) respondents were only fairly satisfied with their breaking bad news skill, while 130(65%) were eager to get training in this regard. The knowledge regarding breaking bad news protocols was lacking across all comparisons (p>0.05).

Conclusion: Majority of the residents had little satisfaction regarding their breaking bad news skill. It is necessary to plan special training for the residents in this key area.

Keywords: Breaking bad news, Communication skills, Evaluation, KEMU, Postgraduate resident. (JPMA 69: 695; 2019)

Introduction

Breaking bad news (BBN) to the patients and their relatives is a complex and stressful task. This communication skill is important as almost all physicians and surgeons have to break the bad news multiple times in their lifetime.[1] Bad news is defined as 'any news that drastically and negatively alters the patient view of her or his future'.[2] The ability to provide this information may either strengthen or destroy the patient-physician relationship.[3]

Despite the importance of this skill in clinical practice, formal education for medical students to communicate bad news has been limited. Literature from the United Kingdom and the United States stressed upon need of structured training of medical students and residents in breaking the bad news.[4] But in our setup, this communication skill is usually learned through trial and error or observation of senior colleagues.[2]

There are many protocols for breaking the bad news, like Background; Rapport; Explore; Announce; Kinding; Summarise (BREAKS), Advance preparation; Build a therapeutic relationship; Communicate well; Deal with patient and family reactions; Encourage and validate emotions (ABCDE), and Setting and listening skills; Patients perception; Invitation to give information; Knowledge; Explore emotions and empathise; Strategy and summarise (SPIKES) model. Though they have almost similar component, SPIKES model is the most commonly followed in clinical scenarios.[5]

Local data on this aspect is scarce. Abbas et al. showed that 40% of the doctors working in palliative care setting in Pakistan could not break the bad news properly.[6] While Jameel et al. showed that 85% of the participants were not comfortable in breaking the bad news.[4] The current study was planned to evaluate the BBN skill of postgraduate residents in a tertiary care setting.

Subjects and Methods

The cross-sectional descriptive knowledge, attitudes and practices (KAP) study was conducted at the King Edward Medical university, Lahore, Pakistan, from January to April 2016, and comprised postgraduate residents of different specialties at Mayo Hospital, Lahore. The sample size was calculated by using 95% confidence level, 4% margin of error with expected percentage communication skills spikes protocol as 9%.[4]

All postgraduate trainees working in medical, surgical and allied wards were included in the study, whereas house officers and consultants were excluded. Those who were absent due to educational leaves were also excluded.

[1]East Surgical Ward, [2]Pathology Department, [3]Allied Health Sciences, [4]Plastic Surgery, King Edward Medical University Lahore, [5]East Surgery, Mayo Hospital Lahore.

Correspondence: Fakeha Rehman. Email: sohnia@gmail.com

ANNEXURE: CASE REPORT FORM

Breaking Bad News skill of postgraduate residents of tertiary care hospital of Lahore, Pakistan. A Cross-sectional survey

1. Age: __________
2. Sex:
   Male Female
3. Training Department:
   Medicine and allied ….......Specify:______________________
   Surgery and allied......... Specify:______________________
4. Year of training:
   1st Year 2nd Year 3rd Year 4th Year 5th Year
5. Number of times bad news was broken in last 6 months?
   Never 1-6 times 7 or more times
6. How do you rate your ability of breaking bad news:
   Very Good Good Fair Poor Very Poor
7. Do you feel comfortable in breaking the bad news:
   Always Usually Mostly Rarely Never
8. Do you follow any guidelines for breaking the bad news
   Yes No
9. If yes, specify: ____
10. Have you received any training of breaking the bad news?
    Yes No
11. If yes, then from where you got this training?
    Workshop by university
    Workshop by CPSP
    Workshop by private company
12. If no, then your breaking bad news skills is developed by:
    Observation of the seniors
    Self-study from book/journals
    Self-study from videos/internet
    Hit and trial method
13. Do you want to have any training regarding breaking bad news skills.
    Yes No Not sure
14. Do you know what SPIKES means?
    Yes No
15. Do you know what BREAKS means
    Yes No
16. Bad news was broken at bed side
    Always Usually Rarely Mostly Never
17. Bad news was broken in doctor's office keeping patient's privacy?
    Always Usually Rarely Mostly Never
18. Do you think keeping an eye contact with the patient while breaking the bad news is necessary?
    Strongly agree Agree No response
    Disagree Strongly disagree
19. Do you have in depth knowledge of the patient's problem before starting the discussion?
    Always Usually Mostly Rarely Never
20. Do you have knowledge of cultural and ethnic background of the patient?
    Always Usually Mostly Rarely Never
21. Are you in habit of switching off your mobile phone during conversation?
    Always Usually Mostly Rarely Never
22. Do you avoid interruptions while breaking the bad news?
    Always Usually Mostly Rarely Never
23. Do you try to establish the rapport with the patient before conversation?
    Always Usually Mostly Rarely Never
24. Do you try to explore "what does patient knows about his disease" during the conversation?
    Always Usually Mostly Rarely Never
25. Do you break the bad news with patient only?
    Always Usually Mostly Rarely Never
26. Do you break the bad news with patient's attendants only?
    Always Usually Mostly Rarely Never
27. Do you break the bad news with patients in presence of their attendants?
    Always Usually Mostly Rarely Never
28. Do you take permission from the patient before breaking the bad news?
    Always Usually Mostly Rarely Never
29. Do you try not to give complete information to the patient regarding prognosis of the disease?
    Always Usually Mostly Rarely Never
30. Do you avoid to give information to the patient due to family pressure of not telling the patient about his situation?
    Always Usually Mostly Rarely Never
31. Do you give time to patients to discuss their emotions and feeling?
    Always Usually Mostly Rarely Never
32. Do you empathize the patient during conversation?
    Always Usually Mostly Rarely Never
33. Do you make sure that patient has understood what you intended to convey?
    Always Usually Mostly Rarely Never
34. Do you give follow up plan at the end of discussion?
    Always Usually Mostly Rarely Never
35. Do you give any hope to the patient at the end of breaking the bad news?
    Always Usually Mostly Rarely Never
36. Do you give any written material to the patient regarding the conversation?
    Always Usually Mostly Rarely Never

-----------------END-------------------

Subjects were divided into two groups. One group comprised postgraduate trainees (PGTs) working in medicine and allied specialties, and the second group had PGTs working in surgery and allied specialties. List of the PGTs was obtained from the registrar office and PGTs were selected by simple random sampling technique using the computer-generated method. Written informed consent was taken from all the subjects, and approval was obtained from the institutional review committee. Data was collected using pre-designed, pre-tested questionnaire (Annexure) which was validated after the discussion with academic members and subject specialists for content validity. All the respondents received a short and simple self-administered questionnaire in English, with a covering letter explaining the project and stating their rights as respondents to the survey. An interview-based questionnaire covering all the aspects of the SPIKES protocol was conducted by the

same research team member to assess BBN skill of PGTs. The questionnaire consisted of two sections. The first section was regarding personal details of the postgraduate residents including age, gender, department and year of training. The second section consisted of 31 items was based on the main BBN steps, especially the SPIKES model. Data was analysed using SPSS22. Quantitative variables like age were presented as mean ± standard deviation. Qualitative variables, like gender and responses, were presented as frequencies and percentages. Association between medical and surgical wards was calculated with chi square test. P<0.05 was considered significant.

Results

Of the 200 respondents, 141(70.5%) were males and 59(29.5%) were females. Overall mean age of the sample was 23±2.55 years. Of the total, 94(47%) respondents were only fairly satisfied with their breaking bad news skill, while 130(65%) were eager to get training in this regard. The knowledge regarding breaking bad news protocols was lacking across all comparisons (p>0.05) (Table-1).

BBN skill of 85(65.9%) residents was developed by simple observation of their seniors who didn't receive any BBN training. A total of 104 (54.2%) residents had to break bad news several times in the preceding six months. There was no difference between the residents of surgical and medical wards (p=0.44).

Communication skills of each resident was assessed based on the SPIKES model (Table-2). Overall, 76(37.8%) individuals usually established rapport with the patient before BBN. Only 38(18.9%) respondents indulged in BBN to patients whereas 69(34.3%) did it to the attendants only due to family pressure. Only 19(9.5%) provided written material to the patient or attendants regarding complete understanding of the disease process. The only

Table-1: Perception of breaking bad news skill of postgraduate residents.

	Gender			Department			Year of training					
	Male 141	Female 59	p value	Surgery & Allied 97	Medicine & Allied 103	p value	1st yr 74	2nd yr 35	3rdyr 31	4th yr 50	5th yr 9	p value
How do you rate your ability of BBN?												
Very good	20	5		10	15		11	4	2	7	1	
Good	46	28	0.32	41	33	0.44	21	11	16	20	5	0.69
Fair	70	24		44	50		38	19	11	23	3	
Poor	4	2		2	4		3	1	2	0	0	
Very poor	1	0		0	1		1	0	0	0	0	
Do you feel comfortable in BBN?												
Always	15	2		9	8		5	4	0	7	1	
Usually	53	19	>0.05	34	38	0.79	23	10	14	20	5	0.35
Mostly	46	11		31	26		22	12	11	9	3	
Rarely	17	15		14	18		15	7	2	8	0	
Never	10	12		9	13		9	2	4	6	0	
Do you follow any guidelines for BBN?												
Yes	71	30	0.91	50	51	0.83	33	21	18	23	5	0.45
No	71	29		48	52		41	14	13	28	4	
Have you received any training of BBN?												
Yes	56	34	0.01	42	48	0.55	16	20	19	29	5	>0.05
No	86	24		56	54		58	15	12	21	4	
Do you want to have training regarding BBN?												
Yes	93	37	0.75	66	64	0.35	45	25	20	35	4	0.78
No	48	22		31	39		29	9	11	16	5	
Do you know what SPIKES means?												
Yes	35	5	>0.05	17	23	0.39	15	9	4	11	1	0.69
No	106	54		80	80		59	26	27	39	8	
Do you know what BREAKS means?												
Yes	55	11	>0.05	30	36	0.48	28	15	12	10	1	>0.05
No	87	47		68	66		46	20	19	40	8	

BBN: Breaking bad news
SPIKES: Setting; Patients perception; Invitation to give information; Knowledge; Explore emotions and empathise; Summarise
BREAKS: Background; Rapport; Explore; Announce; Kinding; Summarise.

Table-2: Communication skills required for breaking bad news.

Questions	Always	Usually	Mostly	Rarely	Never
Bad news was broken at bed side	12(6%)	94(46.8%)	45(22.4%)	23(11.4%)	27(13.4%)
Bad news was broken in doctor's office keeping patient's privacy?	28(13.9%)	67(33.3%)	66(32.8%)	16(8%)	24(11.9%)
Do you think keeping an eye contact with the patient while breaking the bad news is necessary?	82(40.8%)	98(48.8%)	12(6%)	9(4.5%)	Zero
Do you have in depth knowledge of the patient's problem before starting the discussion?	73(36.6%)	72(35.8%)	6(3%)	49(24.4%)	1(0.5%)
Do you have knowledge of cultural and ethnic background of the patient?	32(15.9%)	70(34.8%)	43(21.4%)	55(27.4%)	1(0.5%)
Are you in habit of switching off your mobile phone during conversation?	27(13.4%)	37(18.4%)	55(27.4%)	34(16.9%)	48(23.9%)
Do you avoid interruptions while breaking the bad news?	57(28.4%)	70(34.8%)	15(7.5%)	55(27.4%)	4(2%)
Do you try to establish the rapport with the patient before conversation?	38(18.9%)	76(37.8%)	17(8.5%)	65(32.3%)	5(2.5%)
Do you try to explore "what does patient knows about his disease" during the conversation?	58(28.9%)	76(37.8%)	12(6%)	54(26.9%)	1(0.5%)
Do you break the bad news with patient only?	2(1%)	38(18.9%)	68(33.8%)	56(27.9%)	37(18.4%)
Do you break the bad news with patient's attendants only?	14(7%)	69(34.3%)	34(16.9%)	71(35.5%)	13(6.5%)
Do you break the bad news with patients in presence of their attendants?	11(5.5%)	49(24.4%)	57(28.4%)	60(29.9%)	24(11.9%)
Do you take permission from the patient before breaking the bad news?	21(10.4%)	50(24.9%)	58(28.9%)	26(12.9%)	46(22.9%)
Do you try not to give complete information to the patient regarding prognosis of the disease?	14(7%)	44(21.9%)	61(31.3%)	40(19.9%)	42(20.9%)
Do you avoid to give information to the patient due to family pressure of not telling the patient about his situation?	5(2.5%)	50(24.9%)	64(31.8%)	49(24.4%)	33(16.4%)
Do you give time to patients to discuss their emotions and feeling?	40(19.9%)	76(37.8%)	28(13.9%)	45(22.4%)	12(6%)
Do you empathize the patient during conversation?	43(21.4%)	80(39.8%)	18(9%)	58(28.9%)	2(1%)
Do you make sure that patient has understood what you intended to convey?	67(33.3%)	75(37.3%)	6(3%)	53(26.4%)	Zero
Do you give follow up plan at the end of discussion?	63(31.3%)	72(35.8%)	10(5%)	55(27.4%)	1(0.5%)
Do you give any hope to the patient at the end of breaking the bad news?	42(20.9%)	58(28.9%)	38(18.9%)	53(26.4%)	10(5%)
Do you give any written material to the patient regarding the conversation?	8(4%)	19(9.5%)	74(36.8%)	18(9%)	79(39.3%)

positive association was found between gender and BBN training ($p<0.05$).

Discussion

A major dilemma that healthcare providers are facing in the modern era is conveying of diagnostic and therapeutic facts and figures related to the disease of patient.[7-9] This study provides a valuable local perspective about the knowledge, awareness and attitudes of residents at Mayo Hospital with regards to the bad news broken to the patients. Patients today expect their physicians to give honest information about their health status.[10]

This study, therefore, provided an insight to better understanding of physician's pursuit in providing a better standard of care to their clients. Almost half of the respondents didn't follow any BBN guidelines to the patients or attendants whereas a significant majority was not aware of the SPIKES model.

Almost one-third of the respondents in our survey (65%) were quite eager to receive BBN training. This is comparable to the results of a study conducted in Dutch medical schools where most residents recommended longitudinal programmes with experiential skills training sessions and clinical practice, and to involve simulated patients, physicians and psychologists in training programmes as well as practising physicians who may supervise students during clinical work.[11]

Most of the patients wish the news to be broken to them verbally at a peaceful place. Studies have revealed that an ideal location for a physician to do BBN is one that is comfortable, quiet, private with minimal interruptions and large enough to accommodate multiple staff and family members, if they are present[6,10,12] In our study, 35% participants took permission from the patients before BBN. In another study, 63% patients wanted the doctors to take explicit permission from them before BBN.[10] In our study, more than half the residents (58%) reported that they avoided giving information to the patient due to family pressure of not telling the patient about their situation. This is comparable to a study in which doctors described communication patterns mainly formed by their work experience and often guided by the patient's family requests. Doctor, patient and family characteristics and organisational features and resources were reported to affect the delivery of bad news.[13] The patient's emotional reaction in response to a bad and unexpected news is a big challenge for most of the physicians. It is also an important component of the 6-step SPIKES protocol.[1] In our survey, 37.8% residents gave time to the patients to express their feelings and emotions after a BBN session. A study recommended that the physician should assess and respond to the emotional reactions and be attuned to the body language of the patients after listening to the bad news.[14]

Very few patients were usually provided with the written

material explaining the disease course, therapeutic strategies and prognosis owing to the decreased literacy rate of the patients and lack of training workshops on BBN for the residents.

It is evident from our study that interpersonal communication skills and professionalism are the mainstay of the process of achieving a desirable satisfaction level of the patients with their physicians while getting bad news.[15-17] A study conducted to determine the efficacy of communication skill training for giving bad news revealed that it significantly improved the skills of postgraduate medical residents.[18]

There are some limitations of the current study. Firstly, the population selected comprised PGTs so it was not representative of the entire population. Secondly, verbal skills of the participants were not monitored. Thirdly, patient's perspective and feedback regarding a physician's communication skills was not considered.

Future studies should focus on the involvement of practising physicians, validation of both verbal and non-verbal techniques and monitoring effects of improved communication skills in terms of patients-level outcomes.

It is strongly recommended that doctors' BBN skills should be enhanced using different simple techniques, like training courses, conducting workshops, adoption of a step-wise protocol and focussing to remove barriers to communication in an effective and sympathetic way.

Conclusion

Majority of the residents had little satisfaction regarding their BBN skills. It is necessary to plan special training for the residents in this key area.

Conflict of Interest and Source of Funding: None to declare.

Disclaimer: The article has not been previously published or represented in any conference or any other relevant information.

References

1. Baile WF, Buckman R, Lenzi R, Glober G, Beale AE, Kudelka AP. SPIKES-a six-step protocol for delivering bad news: application to the patient with cancer. Oncol. 2000; 5:302-11.
2. Narayanan V, Bista B, Koshy C. 'BREAKS'Protocol for Breaking Bad News. Indian J Palliat Care. 2010; 16:61-5.
3. Kiluk JV, Dessureault S, Quinn G. Teaching medical students how to break bad news with standardized patients. J Cancer Edu. 2012; 27:277-80.
4. Jameel A, Noor SM, Ayub S. Survey on perceptions and skills amongst postgraduate residents regarding breaking bad news at teaching hospitals in Peshawar, Pakistan. JPak Med Assoc. 2012; 62:585.
5. Back AL, Arnold RM, Baile WF, Tulsky JA, Fryer-Edwars K. Approaching Difficult Communication Tasks in Oncology. CA: A Cancer J Clin. 2005; 55:164-77.
6. Abbas S, Muhammad S, Mubeen S, Abbas SZ. Awareness of palliative medicine among Pakistani doctors: a survey. J Pak Med Assoc. 2004; 54:195-8.
7. Abbaszadeh A, Ehsani SR, Begjani J, Kaji MA, Doplani FN, Nejati A,et al. Nurses' perspectives on breaking bad news to patients and their families: a qualitative content analysis. J Med Ethics Hist Med. 2014; 7:1-7.
8. Slowthwr A. Truth-telling in health care. Clin Ethics. 2009; 4:173-75.
9. Hancock K, Clayton JM, Parker SM, Walder S, Butow PN, Carrick S,et al. Truth- telling in discussing prognosis in advanced life-limiting illnesses: a systematic review. Palliat Med. 2007; 21:507-17.
10. Ishaque S, Saleem T, Khawaja FB, Qidwai W. Breaking bad news: exploring patient's perspective and expectations. JPak Med Assoc. 2010; 60: 407-11.
11. Van Weel Bomgaurten EM, Brouwers MH, Grosfeld F, Jongen FH, Van DJ, Bonke B. Teaching and training in breaking bad news at Dutch medical schools: A comparison. Med teach. 2012; 34:373-81.
12. Keating DT, Nayeem K, Gilmartin JJ, O'Keeffe ST. Advance directives for truth disclosure. Chest. 2005; 128:1037-9.
13. Oikonomidou D, Anagnostopoulos F, Dimitrakaki C, Ploumpedis D, Stylianidis S,Tountas Y. Doctors' perceptions and practices of breaking bad news: a qualitative study from Greece.Health Commun. 2017; 32:657-66.
14. Vandekeift GK. Breaking bad news. Am Fam Physician.2001; 64:1975-8.
15. Eid A, Petty M, Huchins L, Thompson R. Breaking bad news: standardized patient intervention improves communication skills of hematology-oncology fellows and advance practice nurses. J Cancer Educ. 2009; 24:154-9.
16. Bou Khalil R. Attitudes, beliefs and perceptions regarding truth disclosure of cancer-related information in the Middle East: a review. Palliative Support Care. 2013; 11:69-78.
17. Hebert HD, Butera JN, Castillo J, Megra AE. Are we training our fellows adequately in delivering bad news to patients? A survey of hematology/oncology program directors. J Palliat Med. 2009; 12:1119-24.
18. Back AL, Arnold RM, Baile WF,Fryer-Edwards KA, Alexander SC, Barley GE,et al. Efficacy of communication skills training for giving bad news and discussing transitions to palliative care. Arch Intern Med. 2007; 167:453-60.