

# Breaking Bad News

## A tutorial approach for medical students:

### Overview and rationale

#### Introduction

One of the commonest complaints that patients make about doctors in hospital is that they are not very good communicators. This applies whether the doctors are relating to the patients or to the patients' relatives. In response to this problem and to numerous requests from medical students and junior doctors that the medical school help students to improve their communication skills, we have initiated this brief course.



#### Overall Aims:

To improve the communication between patients and doctor (eliciting patient's fears and anxieties etc.) and between doctor and patient (communicating compassion and empathy etc.). In particular, to learn what is important about the setting and style of a consultation in which bad news is given and to begin to help students understand some of the words that patients find helpful and those which are usually unhelpful or even harmful. A related aim is to make the students aware of the *importance* of developing such skills.

#### Specific Aims:

- 1 Understand the importance of improving skills in giving patients bad news.
- 2 Understand that this is a skill, i.e. that it must be learnt and practiced.
- 3 Understand that the overall objectives of this tutorial is to learn how to give patients bad news
- 4 Understand that compassion is not enough when dealing with patients - that it needs to be expressed appropriately.
- 5 Understand the difference between communication of FACTS and communication of FEELINGS.
- 6 Know how to deal with emotionally charged situations, i.e. when:
  - Patient or relative cries
  - Patient or relative is angry
  - Student feels like crying (or does cry)
- 7 Understand the importance of the components of the 'bad news' consultation:
  - a) the setting (privacy; quietness; no interruptions (e.g. mobile phones, pager); offer/expect to have partner or close relatives present; allow plenty of time.....)
  - b) the style (be at eye-level e.g. sit down; make eye contact; appropriate touch; empathetic body language...
  - c) the content (don't start with lots of trivia; be clear and don't use jargon; ask the patient not the relatives, exactly how much he/she wants to know about the prognosis etc.....)
- 8 Begin to understand how to talk to grieving/angry relatives and friends.

#### Background

Bad news for patients is anything that makes the future look dark for them. It could be anything from hearing about cancer, hearing of the death of a loved one, hearing a diagnosis of a disabling disease e.g. Multiple Sclerosis, hearing about the need for an operation or a type of therapy. What is clear is the way that this news is transmitted to patients has profound effects. It is long remembered and can have a profound effect on the patients and / or the family e.g. in being able to handle grief following death. It has been said that "grief handled well makes you *better*" and "grief handled badly makes you *bitter*". There is no doubt also that giving bad news also has a profound effect on the doctor who delivers the news,

particularly, in terms of the induction of stress due to the uncomfortableness of that situation, particularly if the person is untrained in that area, often producing avoidance strategies.

It has been well documented that doctors do not perform very well when giving bad news to patients particularly when those patients or relatives have been surveyed. However it is also fair to say that most doctors have not been taught this skill. Indeed a recent survey of Oncologists showed over 80% had never been taught to communicate bad news. Unfortunately, a lot of doctors assume they perform well when objective measurements do not support that view.

It is logical to begin to train medical students in this skill in the early part of their medical course. Training in communication skills is undertaken in most medical schools in a pre-clinical arena, in bedside tutorials and in a palliative care environment to some extent. But we became aware of the difficulty that some medical schools have in developing an extensive program in communications skills as applied to giving bad news to patients because of the requirement to generate time in competition with other compelling requests in an overloaded curriculum, the need utilise scarce staff and patient resources, the tendency to compartmentalise these skills if they are only delivered by a psychiatrists / psychologist and the problem that pre-clinical training in these skills does not provide immediate application because the students do not have close contact with patients. For this reason we established and evaluated a tutorial approach aimed at teaching students the basic skills, using as tutors physicians who are actually required to give bad news to patients in their practice.

This document reviews the outcome of that program and provides specific recommendations with regard to why, when, whom and how such teaching of these skills could be undertaken.

### **When is this skill taught?**

This course is run in the first clinical year = i.e. when students have one on one relationships with patients on a regular basis.

In the early phase of this program the course was run in the final clinical year. However the students found that it was inappropriate because they were to focussed on exams and anxious about them and because they felt it was a bit late in their training for them to be able to practice those skills. For these reasons we moved the teaching into the first clinical year and this has been quite successful. At that stage students are receptive to teaching, especially teaching done by “those who are required to practise those skills”. In the fourth year of the course the students are more open to the broader aspects of clinical bedside medicine and, most importantly, have three years in which to practise skills learnt on each of their patients.

Despite having a program in communication skills in the medical school, the majority (85%) of students in their first clinical year have never been specifically taught how to give bad news to a patient.

To our surprise, we have found that 66% of these medical students have had a patient cry in front of them, even at such an early stage in their clinical experience. This has been a consistent finding over the 20 years that we have run this tutorial program. This tended to occur at three key points in the consultation, when taking the family history, when asking about the patient’s psychosocial status and when discussing prognosis. Importantly, 43% of students said that they felt uncomfortable in that sort of situation.

Therefore it is clear that from the earliest clinical years students are exposed to emotionally tense clinical situations in which they feel uncomfortable.

Equally importantly, although few students have cried in front of patients (4%) a much larger proportion have cried about a patient (13%) and an even greater portion had felt like crying but have held themselves back (46%). In parallel with this, 26% of students felt that they were emotionally too soft to be doctors. Therefore it became clear to us that it was essential to address not just skills, but the affective components of the relationship between a doctor and a patient in such situations.

### **History of Course**

The course was initiated in 1990 in the 6th year medical specialities term as a joint venture between the University Department of Medicine, QEII Medical Centre and the University Department of Psychiatry & Behavioural Science. Based on student feedback we have changed the course to the medical term in 4th year so it could become a foundation for clinical training in subsequent years, and the course is now run by the School of Medicine & Pharmacology.

### **Context of the Course**

This course is clearly focused on communication skills within the hospital context. It is complementary to training undertaken in other sections of the course, eg. through the Departments of General Practice and Psychiatry and Behavioural Science, and is also complementary to the Palliative Care course for students.

### **Who Teaches the Course**

When this course commenced the teaching was done almost exclusively by trained clinical psychologists. Overwhelmingly, the students requested that they be taught by practicing physicians and not by psychologists. They felt that while the psychologists were very skilled, they did not actually have to give bad news and therefore were always speaking abstractly. For this reason the teaching has been done largely by physicians since then, mostly those practicing in respiratory medicine, oncology or palliative care with the support of psychologists and psychiatrists, particularly in the planning and evaluation of the program, rather than its delivery. In addition to the “authenticity” brought about by the tutorial being delivered by someone who actually has to undertake the task in clinical practice, it also provided an ideal opportunity to teach using quotes and personal experience, methods which have proven to be effective teaching tools in this sort of tutorial.

So, in response to student feedback, the bulk of the course is undertaken by practising clinicians. They want to hear from those who actually have to do it, not those who know the techniques but don't have the experience of actually doing it.

### **Structure of the course**

It is not a set of didactic tutorials but rather represents a number of discussion sessions. This enables the students to ‘own’ the approach. Also, by placing themselves in the position of someone who is about to get bad news, automatically they learn more than if they were simply told the ‘rules’. Occasionally video has been used. We have taken a video of one of the tutorial sessions with a view to using it in later sessions, but the photography was not great. It is available in case someone wants to view the process. We also have a stress management video available for use with the students in the second session on self care – it discusses relaxation techniques etc. It can be very useful. Occasionally supervised interviews have been undertaken and students conduct at least one interview in the presence of a tutor experienced in clinical communication skills. The tutor remains in the background whilst the student conducts a medical interview, eliciting some standard medical information but attempting to put into practice the skills discussed in the previous weeks. The tutor then undertakes personal feedback to the student and, where appropriate, model the appropriate techniques. These supervised interviews have been postponed until enough supervisors can be found.

## **B. The Course**

Groups of ~25-30 students meet with an individual tutor for a period of ninety minutes.

### **Openings**

The tutorial tends to begin in much the same way. I have tended to vary the opening for interest sake but in general I raise a few key points at the beginning [for more details of the opening, see below]

1. “Who can remember what they were doing when Princess Diana had been killed in a car accident”?  
Most everybody can, which provides an opportunity to describe the way in which shocking news burns its way into an individual's memory. Given that none of them knew Princess Diana it is easier for them to realise how getting bad news about cancer would burn its way into the individual's memory.
2. The way in which bad news is delivered and the way in which grief is managed have a major impact on the survivors. “Grief handled well makes people better” and “grief handled badly makes people bitter”.
3. The most powerful opening is to read the students a letter that was written by an intern at hospital. It describes how he was required to speak to the father of a young girl that had died in a traffic accident. She describes how hard it was but says that three years earlier she remembered what she had learnt in a tutorial, in particular that it was okay to cry in front of patients and it was not always necessary to speak and that silence was appropriate in such situations. This letter has the dual effect of providing them with real situation, something that they themselves may face in years to come, and encouraging them that this tutorial can make a difference to how they function when they are doctors.

This teaching seminar is effective because it is relevant to what the students are doing now, rather than being just theoretical. It is therefore important to bring them right in to the issue by opening with a relevant situation - #1 is the most effective. Throughout the tutorial I talk about situations that I was in, focussing on those that I could have handled better. I find students relate well to these stories, probably because it is similar to their clinical teaching i.e. it is case-based and real.

Currently I prefer opening #1.

Other content and examples depend on how the group dynamic is going. For example, when there are a lot of Muslim students in the group it is important to be able to discuss with them the different cultural views on death, how much a patient should be told, who should tell them, what words should be used. Similarly the mature age women, especially if they have undertaken prior training in nursing or social work, are often far more advanced in their understanding of these issues in contrast to those at the other end of the spectrum eg 21 year old males who are immature and have lived all of their life at home. The latter often look aghast as they hear the women talking about the approaches they would take – I often imagine these young men to be saying in their minds "how the hell do these women know all this?".

### ***#1 Letter from an Intern***

Recently an intern bounced up to me and thanked me profusely for running this communications course when she was student because she had to deal with a difficult situation in emergency that required some understanding of communication and crying etc. She kindly wrote down her description of the event and I have recently begun using this to introduce the first week. The advantages of using this letter are that it reminds the students that the communications course may have some value and that it won't be long before they will need to use whatever communication skills they have.

### ***#2 Have any of you had a patient cry in front of you?***

From experience 50-60% of any fourth year medical student group have had a patient breakdown and cry in front of them. This occurs even if it is the students first clinical term. Almost always the patients breakdown and cry in two situations, when they are talking about their family history (eg when one of their children or their partner has died etc) or when talking about their prognosis (i.e. breast cancer and I am afraid etc). Interestingly, it is much less common for patients to cry in front of final year medical students, interns or registrars, presumably because the latter are more focused. Fourth year students however take longer to obtain a full history and in the process, are more "wide-eyed" and interested in the patient's story.

At that point it is helpful to ask the students who have had a patient cry in front of them what the situation was and allow them to describe it. I then ask how comfortable they felt with the patient crying and what they did at the time. I have noticed that over the past 10 or 11 years students have become much more appropriate in the handling of such a situation ie they have often been quiet, touched the patient's hand, passed the patient some tissues etc rather than feeling the need to intervene with words. Nevertheless almost all students feel some level of discomfort in such a situation and one aim of this course is to begin to encourage the students to develop their level of communication skills in such situations to the level at which they feel will eventually feel comfortable in their ability to handle such a situation well.

Sometimes I take this opportunity to present a different scenario to the students ie six medical student friends are having a dinner party and, during an innocent conversation about their experiences the previous week on the wards, one of the students unexpectedly begins to sob. I ask the students how comfortable they would feel in such a situation and what they would do. Almost always in an Australian environment one of two things would happen, either the situation would be trivialised or someone would make a joke. Rarely do individuals feel comfortable in their ability to handle such a situation. By bringing that type of scenario into the discussion it enables all students to understand the need to develop their skills at handling such situations.

### ***#3 What makes a good doctor?***

All students want to graduate as good doctors. It is helpful in their study for them to continue to ask themselves will this study make me a good doctor or am I just learning it to impress somebody? It is important that they understand that we only test one of the four major components of being a good doctor

i.e. competence. We cannot test compassion and conscientiousness. Furthermore, compassion is not equivalent to communication. Many a doctor has felt compassion for a patient and inadvertently said the wrong thing, and in so doing has caused harm rather than been helpful. At this point I ask the students whether they can recall in their own life such a thing happening i.e. when they have said the wrong thing to somebody and afterward wished they had the time over again so that they could say it differently. Every student nods enthusiastically at this point and it is quite a useful way to make them realise that compassion is not enough, they need to develop communication skills so that their compassion is translated into helpful dialogue rather than potentially hurtful statements.

#### ***#4. Personal experience***

We ask the students if they had any examples of bad news being communicated to patients.

Almost their entire experience of the giving of bad news is negative i.e. it occurred on a ward round in which there were many doctors, nurses and students present which is generically a poor model (of course when bad news is told well, very few students are present so it is unlikely that they will have seen a good model of bad news being told – a corollary of this is that it is a good idea to take a student with you when you are giving bad news to a patient, preferably the student who is clerking that patient.

In giving an example of bad news being told badly, one student described how her aunt, who had a breast lump, had delayed seeing her doctor such that at the point that she was referred to the teaching hospital for surgery, it was locally well advanced. The surgeon felt sorry for her but said "you silly woman – how could you have let it go for so long?" The woman was deeply hurt by this. Indeed at this point the student who was telling the story got upset (she later said that this aunt was like a mother to her) and had to leave the room. Another student went out to comfort her. Of course it is important to debrief such students immediately after the tutorial, which I did.

Sometimes I ask them if they have seen anyone told the bad news, either a patient or a relative. I ask them to describe the situation and how they evaluated it. Almost always the students have an innate perception as to what is good and what is bad about the way in which the news was told.



#### ***#5 Long term memories of grief – will they be helpful or hurtful as doctors?***

At some stage I ask a question such as "what were you doing when you heard that Princess Diana had been killed?". Of course in my generation it such questions relate to JFK, Elvis etc. The point to be made is that such profound news pierces peoples' memory banks, like a laser beam, lodging there forever. How you break bad news is the first part of the grieving process, and the following is a crucial point to be made with the students: **GRIEF HANDLED WELL CAN BE AN ENRICHING EXPERIENCE FOR THE SURVIVORS WHEREAS GRIEF HANDLES BADLY CAN BE DISABILING.**

Surviving relatives in whom grief has been handles well can often draw close to each other, become empathic with others etc. Whereas grief handled badly can often produce anger and bitterness which spills over into family dynamics, the work place, perpetuating a cycle of dysfunction. I remind students that such events are rare in the life of an individual, and as a doctor, you are automatically inside peoples' inner sanctum. As such there is a major responsibility to handle the situation with delicacy and care. Just as a neurosurgeon is not allowed to operate on a brain without training, so doctors need training to handle this delicate situation – guess work and good intentions are not enough.

### **C. Case scenario**

I present the students with a true case scenario i.e. a patient whom I have been investigating whom I find out has cancer. The patient is on the ward and I need to go over and tell him the bad news. As with all clinical teaching, it is important to try to present a real case rather than a made-up case. This is my case:

*"A 42 year old pharmacist is in the ward. He is a smoker and is being investigated for a pulmonary shadow. Investigations confirm non small cell lung cancer metastatic to the liver and bones .i.e. a largely untreatable stage 4 lung cancer with a prognosis of approximately 3 to 4 months. He is married with two teenage children."*

I ask the students to break into pairs and discuss with each other what they consider to be important about the setting, the style and the content of what I say. I then give them about 15 minutes to discuss with each other what they would consider to be important if they were the patient getting the bad news. Of course the following information needs to be illicit.

### **Setting.**

1. A private location
2. No interruptions eg turn off mobile phones, pagers etc.
3. Make enough time
4. Invite a relative to be there if that is what the patient requests
5. Set up this meeting time in advance so that they can be ready for it.

**NB** This provides the opportunity to highlight two key issues. Firstly, the notion that individuals have preference and that the doctor ought not to be guessing what those preferences are, but to check with the patient in advance.

It is a lot easier to tell a patient "I will have the results of the biopsy by Friday". "As you know it could be a tumour or it may be something else."

Given that it might be a tumour, if that is what we talk about on Friday is there a family member who you would like to be with you at the time?" Usually the students talk about the fact that to make such a plan would create an anxiety in the patient, however we make it clear that the anxiety is not a problem - if the news turns out to be bad then the anxiety has actually helped them adjust to the possibility of bad news and surprisingly "softens the blow".

We make it clear to the students that it is very rare that such information should be delivered over the telephone, which unfortunately does happen and has happened in some of the students experiences.

I also ask the patients if they have ever seen bad news delivered in any other setting. 47% have seen a patient told the bad news almost entirely this has occurred on ward rounds. The student's evaluation of that experience was that in only 37% of those occasions was that news delivered well. Indeed students are often distressed at the way they have seen bad news delivered on ward rounds. Rarely have students ever been able to sit in on situations in which bad news is delivered by someone trained to do it well.

Interestingly, of the 22% of students that have had personal experience of bad news being given to a friend / family member – an identical number 37%, felt that it had been done well.

### **Style:**

1. Sit down on a chair or on the edge of the bed.
2. Make sure that you are at the same eye level ( being at a higher level creates a power differential and makes the patient feel like a child again)
3. Appropriate touch. We remind students that standing with arms folded, looking down ones nose, generating body language that suggests you are in a hurry, simply talking amongst junior staff and not focusing on the patient, not making eye contact and basically continuing on a busy ward round eg discussing the patient's condition from the end of the bed, are all inappropriate ways of delivering bad news.



### **Content:**

1. Don't begin with a long conversation of trivialities, "isn't it a nice day", "how is the family etc".
2. Be more direct so you don't worsen the anxiety eg "Mr Jones, I promised to come back today with the results of your test and unfortunately the results have not gone well". "I am sorry to say that the biopsy shows that it is a cancer that you have in your lung".

Don't be afraid to mention the word cancer, rather than euphemisms like "growth" technical words like "malignancy". In the end the patient may listen to that information and not know that they actually have cancer.

The patient is interested in the answers in four sorts of questions.

- a. What is the diagnosis? Make it clear, write it down and draw a cartoon that they can keep with them.
- b. What are the treatment options?  
What is the prognosis – not all patients wish to know this so ask them in advance eg. "At this point we can talk about prognosis although you may want to leave this until a later consultation". "I will leave this up to you". "Or would you like to discuss this now?"
- c. Support – what sort of support do they have in the family and community.

This is a good time to make it clear to them that you will continue to be their doctor and continue to look after them even though they will be going to other doctors eg radiotherapists, oncologists etc. It is also nice to leave a telephone number for them to contact you should they have further questions.

Whilst they may start with any of these beginnings, I will almost always use the remaining ones at sometimes during the talk. It all depends on how the group dynamic is going. For example, when there are a lot of Muslim students in the group it is important to be able to discuss with them the different cultural views on death, how much a patient should be told, who should tell them, what words should be used. Similarly the mature aged women, especially if they have undertaken a prior course such as nursing or social work, or often far more advanced in their understanding of these issues in contrast to those at the other end of the spectrum eg 21 year old males who are immature and have lived all of their life at home. The latter often look aghast as they hear the women talking about the approaches they would take – I often imagine these young men to be saying in their minds "how the hell do these women know all this?".

## **D. Examples of clinical histories that are useful:**

### **Grief handled badly versus grief handled well**

A 48 year old lady was sent to see me with an unexplained cough. On routine examination of her abdomen I detected an enormously enlarged liver. The patient afterward told me that she saw my brow furrow when I felt the liver. It transpired, on further investigation, that she had a metastatic colonic carcinoma which had been undiagnosed to that point – I never found the cause of her cough. Following the diagnosis I saw her on a follow-up consultation in my office and asked her how she was going. She said she just wanted to die now. "Why is that" I asked? She said because her illness was producing anger and disarray in the family. Her husband was angry because he was grieving and he was taking it out on his son and daughter. The son had moved in with his girlfriend and the father kept saying that his son was living in sin and it was bad timing. The daughter kept coming home in the evenings to visit and expected her mother to wait on her with food, cups of tea etc in the same way that she always did and, to make it worse, the daughter never once discussed her mother's illness. In the midst of all this the patient said she did not want to live anymore and just wanted to die to get away from it all. I organised for the Cancer Foundation family counsellor to visit the family. In addition I went to have my hair cut. This may sound trivial but a coincidence occurred which I think was of benefit. The patient that told me that her daughter was a hairdresser who occasionally did sessions in the hospital hairdressers. When I went down to have my hair cut the young lady cutting my hair began talking to the colleague next to her about scuba diving, one of her hobbies. Her mother had told me that her daughter was a scuba diver so I thought that this might be her daughter cutting my hair. As a naturally shy person I thought that it would be silly to discuss her mother's illness in the hairdressers.

Then I thought about the fact that her mother wanted to die and thought that I should bite the bullet and take the opportunity. I asked the daughter "are you related to Mrs X?". She immediately answered almost before I had finished my sentence, "and you are her doctor I know". I realised that she could not bring herself to mention that directly to me but was dropping hints to the person next to her in the hope that I would catch on. To cut a long story short I discussed her mother's situation with her as best I could whilst having my hair cut. The next I saw of her mother was in the Cottage Hospice in Shenton Park when I went to visit her. When I walked into her room she said "Bruce. Great to see you. I don't know what you said to my daughter but things have been transformed. Now she comes to see me everyday, talks about my illness and lovingly does my hair". I am sure the major factor in the change in the family was the visit of the Cancer Foundation counsellor. It was a good example to me of grief handled badly being transformed into grief handled well.

### **Making sure that a close relative is present when the bad news is given.**

Often students make a judgement as to whether a relative should be present or not. The judgement comes from their own beliefs and values. We try to get them to make the decision based on prior discussions with a patient eg "I will have the results back this afternoon at 2.00pm. I will come and see you then and let you know the results. They may simply indicate infection but the results might be worse than that i.e. it could be a tumour. If that is the case, who would you like to be present when we discuss these results?".

I tell them about a situation in which I made the mistake of telling a patient his results without a relative being present. In fact I use this trilogy throughout this course, telling them about all the mistakes I have made in this area. This is the example I give.

"An old man with a chest mass was diagnosed as lung cancer. I made an arrangement to tell him the news on the ward with his daughter, a business woman, being present. At the arranged time I went to tell him the news but his daughter was not there. I told him anyway. He was a laconic old man who did not mind the news. His daughter however, who arrived about three hours later was hostile towards me because I had not waited for her. I complained that she was three hours late but she was angry at me anyway. Of course she was probably right – it is important that a relative is there. Although in this case it was not important for the patient, it was important for her. I should not have told him and simply come back later when she was present".

### **Talking to the patient's' relative**

In following up a patient with cancer, it is important to show empathy towards the patient's relative, usually their caring partner. In my experience if you ask the relative a direct question such as "how are you going?" they simply answer "fine". As a chest physician, most of my dying patients are male so it is usually a wife that I am talking to. What I have learned is that an empathic question is much more likely to be effective eg "often when a patient is at this stage of his illness, it becomes really hard for the person who is looking after him. I guess this must be really hard for you at this stage?". Often this enables them to say yes it is hard. Indeed, sometimes it represents the first time that anyone has acknowledged that it is hard for the carer (most people, including the patient, have unending expectations of the carer – sometimes the carer is so tired, exhausted and worried that they find themselves wishing that their partner would die quickly to provide them some relief, at which point they then feel guilty).

### **Another example of a caring partner being present.**

I tell the students about the day I had to tell one of the West Coast Eagles that he had cancer. This story does not represent a breach of confidentiality as the patient himself reported it in the media. The patient was sent to me with possible diagnosis of pneumonia as he had chest x-ray infiltrates and breathlessness following an overseas football trip. Clinical evaluation including open lung biopsy showed that he had lymphomatoid granulomatosis, an aggressive lymphoma. I arranged to tell him the news at 5.00pm on a given day and we agreed that his wife would be present. When I told him the news, his head went into a spin. It was only his wife who was able to ask all of the necessary questions (treatment, prognosis, options). If she not been present it would have been impossible to communicate anything to him.



This of course is a common experience – on hearing dramatic news it is impossible to remember much of what is said in the next 10 or 15 minutes. It is impossible to over emphasise the value of having a caring close relative present when the news is given.

### **Leaving the relevant information with them**

Even given the above, it is difficult for patients and their relatives to remember all that is said to them following giving of the bad news. I always leave my mobile and home phone number with them, but they rarely use it. Nevertheless the gesture means that I understand that their uncertainties may create anxiety and they know that I am willing to talk to them. Of more value, I write on a piece of paper for them what I have told them, including a picture of the tumour and the numbers and statistics that we may have discussed during the consultation. I then give it to them and they are able to show it to their children etc who may visit that evening. They can also take it home with them and refer to it later.

### **How much should one tell them?**

Students often discuss amongst themselves how much should be told and make decisions again on their own beliefs and values. We try to emphasise to them that it is important to allow the patient to decide how much they want to know. This can be determined by prior negotiation with the patient ("if the news is bad how much would you like me to tell you?") or, more practically, to tell the patient the diagnosis (assuming this has also been agreed to in advance) and then to make the patient aware that you are willing to answer any questions that he/she may have and invite them to ask those questions.

## **E. Observed interview**

This session begins with a 30 minute discussion with the students about how to talk to grieving or angry relatives of severely ill patients. The last 60 minutes of the tutorial is an interview with a cancer patient and his/her main relative.

One of the most rewarding experiences for the students is to spend an hour interviewing a patient and his/her relative. To set this up I arrange for a patient (almost always one of my own patients) who is sufficiently verbal to provide feed back to the students to come to the interview. I discuss it with them clearly in advance. I make it clear to the students that they can ask any question they like of the patient or the relative having cleared that in advance. They always sit next to the patient and relative in case they get upset, although in my experience this has turned out to be an important experience for the patient/relative as well as for the students (they know that they are helping the students).

I spend the first half hour prior to the interview talking to the students about how to deal with grieving/angry relatives. I remind them that the patient's partner usually suffers as much as the patient during the process of the patient dying (tiredness, worry, exhaustion, grief, mixed emotions etc as mentioned above) and that, putting it bluntly, the relative will be left to survive with their grief long after the patient is dead and released from it. Therefore the management of the patient's relatives is an important part of this process.

We discuss the stages of grief (disbelief, despair and depression, inappropriate hope, anger, acceptance etc) and the different sequence and degree to which each of these stages can be felt. We mention to the students the three rules for talking to angry relatives:

1. **Stop** (i.e. make it clear to the relative that you are prepared to make time in your busy day to talk to them).
2. **Look** (make eye contact i.e. make it clear that you are not just tolerating them but are keen to engage and communicate with them)
3. **Listen** (really listen, don't just bide your time waiting for them to finish before you come back with a defensive answer. If you don't know the answer, promise that you will find out the answer and meet them again the next day etc).

Student feed back analysis reveals that the experience of interviewing patient/relative in this context is one of the most rewarding that they have.

**NB.** Week 2 of this course discusses with students how they can have balanced lives and avoid the burnout that can accompany stressful working environments, like having to break bad news regularly.

## APPENDICES

### Appendix 1: References

#### 1. Breaking bad news needs to be taught.

NB. 87% of med 4 students at UWA have never been taught how to break bad news to patients.

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## **Appendix 2: Letter from an intern [to be read before the tutorial]**

*This was sent to Professor Robinson after she told him of this incident and thank him for teaching her, as a student, how to talk to patients and relatives about bad news.*

One of the most profound experiences of my intern year happened when I have been a doctor just one week. On a hot summer's afternoon in the emergency department, I helped resuscitate the driver of a car that had collided head-on with a bus. A little girl was killed in the crash.

ED was extraordinarily busy that afternoon. Maybe an hour or two later, a nurse approached me, explaining that the dead girl's mother and a younger sister had also been in the car. They appeared uninjured, but needed to be checked by a doctor. I didn't think that I, the new intern, should have been looking after them but amidst the heart attacks and severe asthma, there was simply no-one else available.

Dealing with the little girl who had survived wasn't so bad. Her skin sparkled because she was covered in tiny flakes of glass from a shattered window, but she had no obvious injuries. The reality of the day's events had gone past her. Her mother was also physically unharmed, but emotionally in a distraught numbness. Again and again she told me of the car stopping, and looking the back set to see one daughter screaming and the other not breathing.

By that time, the woman's mother and siblings had arrived. They thought I looked too young to be a doctor. I couldn't tell them I'd only been there a week. I suggested the woman and her daughter see their GP the next day, and that perhaps they stay with the relatives overnight. The hospital Chaplain had already arranged counselling.

The children's father arrived. The family asked would I speak to him too". I had no idea of what I could say, or how I could help, but I also couldn't just refuse.

I sat down with him in the Relatives Room. It was cold. I remember thinking that the only way of dealing with this man was to tell him the truth. So I told him I wished I knew what to say. And yet, I knew that nothing I could say would change anything. I told him that too. I left a long pause between these sentences, because I remembered one of my undergraduate tutors say silence was important. So I spent a lot to time saying nothing. And he started to talk. Not in terms of graphic descriptions of "she wasn't breathing, she was dead", but of his little girl. Of the child who had run home from school, delighted with her certificate for winning a swimming race. Of watching her grow up. Of the joy and pride she brought him. I still didn't know what to say. So I still said nothing.

He would stay with relatives, he told me. As with his former wife, I gave him the counsellors contact numbers, and advised a trip to his GP. I was about to stand up to leave when I realised I was starting to cry, and had to sit down again. I don't think I could have avoided crying, but I was still glad that same university tutor had told us all that crying with patients was okay.

I went home that night wondering whether I'd done anything of value and thinking I would never know whether I'd helped these people. I really hoped I hadn't made things worse. Six weeks later, the father rang the hospital chaplain, wanting to know my name, and asking that I be thanked.

### **Appendix 3: Checklist for communication during an interview.**

- a) Patient greeted, mentioned by name?
- b) Eye contact established?
- c) Sit?, eye level?, touch?
- d) Patients' view of his/her illness elicited?
- e) Patients' fears and anxieties elicited?
- f) Patients descriptions clarified?
- g) Patients emotions respected?, encouraged?
- h) Patient encouraged to speak freely without interruption?
- i) Content/emotions reflected back to patient for clarification?
- j) Empathy shown?
- k) Open questions used?
- l) Important clues tuned into? (e.g. words, voice changes, facial expressions, body language)

### **Appendix 4: what are 4 characteristics of a "good doctor"?**

NB. This is a limited list each individual must decide for him/herself what is important, but the public have certain expectations of our profession which are perfectly reasonable, in the same way that we set certain standards for airline pilots, engineers etc.

#### **"The 4 C's"**

- **Competence** (what we measure in exams)
- **Compassion** (we are not machines)
- **Communication** (it is not enough to feel compassion for patients - it is possible to feel compassionate towards a patient and yet say the wrong thing - this will be at least unhelpful and at worst hurtful. It is important to be able to effectively communicate your compassion to patients)
- **Conscientiousness** (it is not enough to be competent, caring and communicative if you don't work hard for the patient's well being).

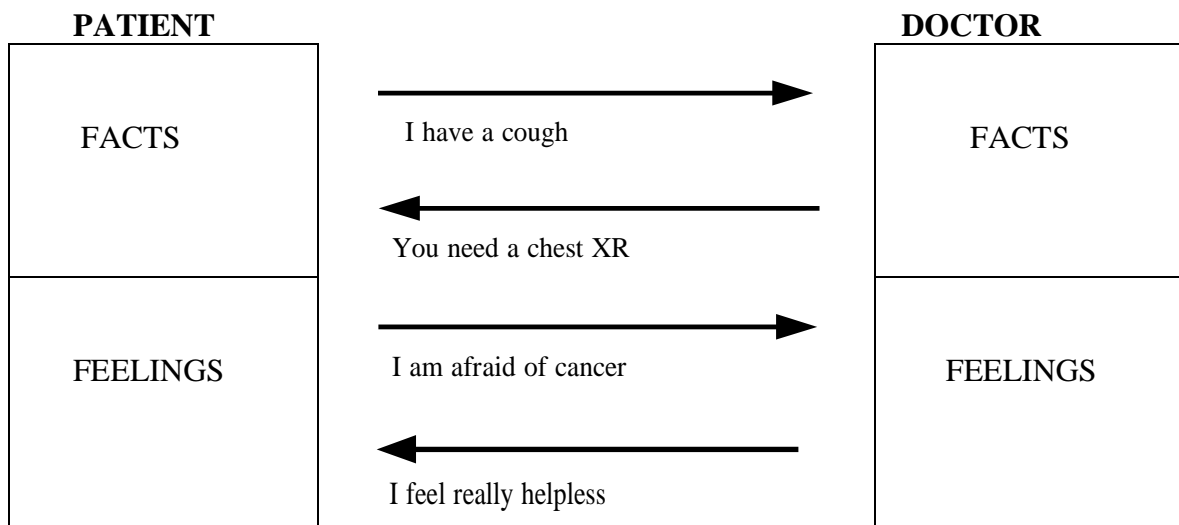
### **Appendix 5: Cartoons that might be useful as overheads.**

#### **5.1. A model for understanding typical doctor-patient relationships and doctor-doctor interactions**

Most interactions are "FACT-to-FACT" or "HEAD-to-HEAD" (or "neck up" communications) i.e. doctor extracts from the patient information (the flow of information from patient to doctor e.g. "I have a cough" plus doctor returning factual information to the patient (tests required, the diagnosis etc.)

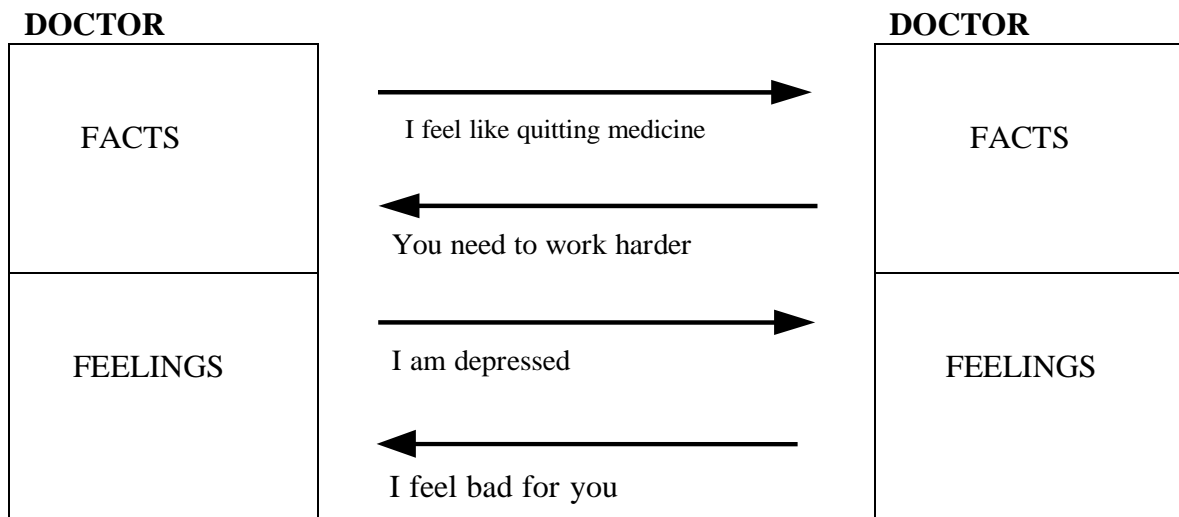
However, people are not simply collections of facts. For most of us our feelings are where we live, where our priorities lie - they are the source of most songs, operas, music, novels etc. and are powerful driving forces in doctors and patients. Therefore to communicate to the whole patient as a complete doctor it seems logical that the 'FEELINGS-to-FEELINGS' communication should occur. An example of this is that the doctor may elicit aspects of the patients fears and anxieties and may also communicate back to the patient his/her own feelings e.g. empathy.

Please note that this is communication, not counselling. Also, it is not any form of sophisticated modern psychology - it is simply an expression of being a whole person not simply a repository of facts.



### 5.2. Doctor-Doctor Communication

Because doctors are traditionally in positions of leadership, they often find difficulty expressing their weaknesses and feelings, particularly most male doctors. Therefore what is taught in doctor-patient communication is equally applicable to doctor-doctor (or medical student-medical student) situations. I often ask the students to practice these skills next time they are talking to one of their medical student friends about life, their course etc.



### Appendix 6: Why should doctors bother trying to improve their communication skills?

It is possible to argue that this sort of training is not necessary. Some argue that

- a) you either have it or you don't - so don't waste your time
- b) you can't be taught these skills
- c) you learn on the job

These comments have usually been made by individuals who have never had any training in the area of communication, who may be quite good at communication with patients but who continue to make the same mistakes without knowing it, because the patients respect them so much that they don't give them any negative feedback on their style.

Other arguments run as follows:

- d) there is not enough time in a consultation to undo the attitudes and problems patients have built up over a lifetime
- e) bluntly, won't get paid any more for adding that extra bit of time and emotional energy to my consultations so I will avoid it
- f) there is too much other stuff to learn in the course to spend extra time on this 'softer stuff'
- g) I am afraid that I will end up carrying the emotional burdens of the patients home to my family and this would interfere with my personal and family life.
- h) I might get 'burn out' (emotional exhaustion) if I do all this empathic communication
- i) I might end up emotionally involved and not be able to make clear decisions and I must be cool and detached in order to be able to concentrate on the main medical problem.

It is worth dealing with these issues if time persists.

Ultimately though it becomes an issue of 'medical lifestyle' i.e. how one chooses to practice medicine/what is important to each individual etc.

### **Appendix 7 – Feedback from the students**

Wow. This session broached a topic which I have always been worried about and never had any decent advice on. I honestly think I now have the knowledge, skill, etc to break bad news well. Prof Robinson's personal experience made the whole thing much more relevant & practical. Amazing tutorial on a unusually poorly taught subject.

I found this tutorial very helpful and it answered many questions that I had asked myself before. Real world examples and role play from someone with experience in delivering bad news were useful. I think I learned some things which I can apply to future practice.

Very effective and useful session.

Definitely worthwhile.

Great as not didactic but revolves around personal experience, success and failure.

Realistic and clinically appropriate.

Well organised and useful..... process in regards to where / what situations is appropriate, about importance of rapport and style but particularly what work, and phrases are appropriate.

Importance of giving patient what information they want.

Good opportunity to have something explained that I have often wondered about whether or not I would know what to do in that situation. Also something I have considered to be one of the hardest parts of the job. Very good to have some things clarified and to think about the process in detail. Cheers.

An **excellent** introduction to this important area of medicine.

I would love a few more sessions where we can address our own fears a little more.

I also think a session about breaking the news of a patient's sudden or unexpected death to relatives might also be good.

Beneficial session.

Glad to know what - I am doing right .  
I can improve on else I should do.

Sharing of stories made the session more personal and engaging.  
Thank you!

Should continue to offer this, it was explicit and gives some specific instructions rather than just the general idea. Could possibly offer a bit of literature also.

Communications skills – breaking bad news.

- Good examples but more would be nice
- Maybe more evidence based guidelines
- Perhaps have a patient / fly member to come down and share their experiences.
- More concrete guidelines and things to say and do

This was a very effective session. I feel this is an important issue which is often skimmed over as no one wants to talk about something so uncomfortable – so it has been really good to have it out in the open. It is also great to have practical advice about location, wards etc. Having someone who actually tells patients they are going to die is also much more valuable than hearing this information from someone who has never been in this situation.

I thought this tutorial about breaking bad news was really good. A lot of real examples were given which made them practical. I hope I'll be able to give patients bad news in an appropriate way in the future as it'll have a really big impact not only on the patients but also on their family. Should definitely be continued.

Thank you for the teaching session. It was extremely helpful in teaching us how to deal with situations that are very awkward and difficult. It is important to have sessions such as these, as many experiences that we have on the wards witnessing consultants giving bad news have not been positive.

Breaking bad news is an extremely important topic.

It is generally poorly done and I believe that this session has given me practical assistance in how this can be done better.

Helping people pass on with dignity and assisting their families to grieve in a positive manner.

Session on breaking bad news –

- very good
- very helpful & insightful
- as a 4<sup>th</sup> year medical student there has been little – no information on breaking bad news – awkward topic to broach – put at ease in facing these situations and made future patient – student / patient – doctor interactions a million times better and more informed.

I think this session was quite helpful.

In previous years we have talked a lot about how to break bad news in theory, but it was helpful to hear Bruce's personal clinical experience and the good and bad things that come across.

I found this talk very useful, having heard some terrible examples of how bad news has been given to patients.

It was helpful to go through all aspects of the meeting with the patient – more importantly what to do and say.

The examples given helped us to think about these situations and the best way to handle them.

The communications session on giving bad news was confronting but a very valuable session. I now feel more prepared to give people bad news. When I am a doctor in a few years and I won't be afraid to let my feelings about a situation show as I was afraid about crying in front of a patient and what is considered acceptable.



I believe I will be a more compassionate doctor as a result of this session which will benefit me and my future patients.

I think this is a very important aspect of medicine and clinical practice.

Providing a tutorial by someone experienced in these matters allows us as students to face the realities of our careers and that there will be times we are called upon to provide bad news.

Discussing some simple techniques is a great way to introduce us to this important area.

Best part was the “play act” where Bruce talked through how he breaks bad news:

That illustrated

- tone
- body language
- words

good value overall.

- This was a very interesting and entertaining tute,
- It was good to be given the OK (and encouraged to) touch patients when it is necessary.
- Also, that it is OK to cry with a patient.
- Also, that being more “blunt” may be more appropriate.
- Lastly that saying “I am sorry” to hear that etc is a good technique.

It was good to be able to examine the process of giving bad news to patients in detail and to work out the issues and approaches. I’m certain it will be helpful.

- This session was delivered very well
- It was really good to have someone do it who does routinely have to break bad news.
- It was helpful in that it has given me the confidence to think that I might actually be able to break bad news in a helpful and appropriate way.
- It was taken some of the scariness out of breaking bad news.
- It is a good place in both the course and the year.
- It definitely needs to be in the course.
- The personal stories really helpful.

In all honesty I wasn’t looking forward to this tutorial. However I found it very useful and a safe encouraging place to talk about the thing that nobody wants to talk about – death. The main thing that I got from this session is the confidence that I can handle this situation when it arises and that I can make a difference to a patient even when it seems like all is lost.

Bruce was very open and honest and made the session very enjoyable as well as beneficial "Student driven: not didactic, rather an open question posed by the dude that we got to think about. And we did: I certainly would have fallen asleep had he tried to make a lecture out of it. Instead I found it very enjoyable".

"Good breakdown in terms of remembering 3 key aspects:

setting, style content. Good to reflect on personal experiences of breaking bad news + critique how well it was performed. i.e. excellent to hear case examples".

"Interesting to hear other people's view and experiences on the topic".

"The trigger (letter from intern) – hearing personal experiences and how people dealt with them – having an opportunity to speak about personal misgivings and that it is hard and there are ways to make it more pleasant for all involved"

"Discussing the optimum setting for breaking bad news"

"Learning more about what is appropriate behaviour / mannerisms when breaking bad news."

"Lots of time for interaction, discussion"

"I found the logical approach i.e. setting, style, content easily palatable although also understanding the difficulties involved (i.e. rational approach to a irrational situation)"

"The tutor was very very good!"

"A repeat later or mini tutes would be beneficial".

"I think the part of why it was helpful is just the recognition that we will need to be giving bad news and we need to be aware of the difficulties involved. While I may not remember the specifics of a tute like this in years to come, I think it helps to start off teaching about good communication and the effect that it has"

"The step by step approach to managing the situation was great"

"The discussion of different ways to do it was helpful, as was the emphasis on meeting the needs of the individual patient".

"It was good to establish what was ok to do in front of the patient and how breaking bad news well could have a positive effect on the patient and their families"

"Tips on time, location and who should be present were also helpful".

"It's good to have a session where we can discuss "how to break bad news", with someone who has had experience to guide us".

"A lot of the time there are things we may already be aware about, but a reminder once in a while is great".

"Very good just to gain awareness of all the potential difficulties and some ways to deal with them, covered well in quite a short time"

"The fact that it was student oriented and so we had to give the answers, But also that no one was pushed to give an answer. It was done in a relaxed manner, allowing time to think and everyone's opinions was appreciated and they were allowed to be aired. When the tutorial began Prof. Robinson told a story about a previous student and their experience with giving bad news. This was a great way to begin as it put the rest of the tutorial in perspective.

The story was good.

The practical tips were excellent.

The chance to think a bit about it before being put in that situation was good.

The letter by the Intern, which was read at the beginning was very helpful.

Good opportunity to ask questions and discuss as a group and to learn the details of what is available to make the giving bad news easier.

Good to talk about an important issue with other people who will go through the same thing. Glad that it was held.

The discussion format and informal setting was good - people were able to share their own experiences and opinions. Going through the process and addressing our concerns at the same time.

"Perhaps role-plays might be an interesting way for us to practice a "real" situation".

Basically just talking about things that maybe we already know, but bring them up in the specific context of breaking bad news to a patient makes you take these things for seriously.

A few tips on how to avoid saying the wrong thing was helpful. So often you say the wrong thing or something that upsets a person when you actually mean well and don't know how to make them feel better.

Subtle things I hadn't thought of before (e.g. taking off stethoscope) and the effect of the environment for breaking bad news.

How do I modify strategies of breaking bad news to people of different cultures /religions e.g. when to you get an interpreter?

## **Appendix 9. Data**

### **Introduction:**

The breaking of bad news is an important skill component in the teaching of communications. A number of studies have demonstrated that doctors do not do this particularly well and are not always aware of their lack of skill in this area. For these reasons our Medical School, along with others, teaches medical students in their clinical years basic communication skills. The aims of this study were to:

Assess the skill level of medical students in their first clinical year in terms of breaking bad news and their level of psychological comfort in such situations.

Evaluate the effect of a single 90 minute tutorial on this subject on their knowledge and comfort level.

### **Methods:**

One hundred and twelve fourth year medical students were evaluated during their internal medicine terms. These were all UMAT / Interviewed selected students.

The single tutorial was planned jointly by a team of clinical psychologists and clinicians experienced in the breaking of bad news. The tutorial was delivered by clinicians experienced in dealing with dying patients (respiratory and palliative care physicians). Each tutorial was delivered to groups of sixteen to twenty students at two sites. All tutorials followed the same format which was an introduction (stressing the importance of being able to break bad news well), discussion of the students experience and knowledge and comfort in the area, presentation of a real case for discussion, discussion by the students in pairs for twenty minutes focusing on what they considered to be important in terms of the setting, style and content of the process of breaking bad news then discussion of the outcomes with the tutor.

A questionnaire was administered to all students prior to and two weeks following the first tutorial.

### **Results:**

#### **Student experience**

Almost half (47%) of students had already observed a patient receiving bad news from a clinician. This occurred almost exclusively on ward rounds and only 37% described the process as having being conducted in good or excellent fashion. 22% of students had personally experienced the process of receiving bad news with a similar proportion describing it as having being delivered in a good or excellent fashion. Only 15% of students had been specifically taught how to break bad news prior to this tutorial.

#### **Student ability**

Only 45% of students rated their ability to give bad news as adequate or better. However on objective assessment, around 90% of students could identify three or more important components of the setting, style, and content of the optimal process of giving bad news i.e. their objective knowledge was twice that of their subjective confidence.

### **Level of student “comfort” of the process of breaking bad news.**

By their fourth year in medicine 66% of students had already experienced a patient cry in front of them. This generally occurred during the discussion of either the family history, psycho/social status or prognosis. Interestingly, 51% of students described feeling comfort with handling emotionally laden situations such as having a patient cry in front of them.

Only 4% of students had cried in front of a patient themselves, though 46% had felt like crying but restrained themselves. 13% of students had cried about a patient. 64% of students felt that students or doctors should rarely or never cry in front of patients.

26% of patients described feeling “too soft to be a doctor” because of the level of emotion they felt with dying patients.

44% of students said they openly revealed feelings of fear, anxiety, sadness or embarrassment to friends and family usually or always and 42% describe having friends and / or family opening reveal such feelings to them.

### **Effect of a Tutorial**

Post tutorial evaluation revealed that the proportions of medical students whose level of comfort following the 90 minute tutorial increased. The proportion of students who changed their minds about the issue of whether crying in front of patients was okay almost doubled. 84% of students described an increase in their level of comfort with the notion of breaking bad news to patients. 97% of patients found the tutorials helpful in terms of learning how to break bad news to patients.

### **Discussion on Student Experience:**

Our observation that medical students have had some experience observing bad news being broken, generally on ward rounds in a fairly unsatisfactory way is consistent with published and anecdotal reports. Given the importance of generating a private setting for the breaking of bad news, rather than a impersonal ward round, is logical that very few students would have been exposed to good models of the breaking of bad news. I have personally changed my practice in this regard and try to involve a small number of medical students, particularly those who already have had contact with the patient, during the process of breaking bad news if the patient and relatives are comfortable with that notion. Nevertheless it is likely that students will continue to see bad news being broken inappropriately on wards, highlighting the need for specific tutorials aimed at teaching best practice in this area. The fact that only 15% of students have ever being taught this by their fourth year of a six year medical course reinforces that notion.

### **Student Abilities:**

It was interesting that whilst the majority of students felt that they did not have adequate skills in terms of breaking bad news to patients, when they were presented with a real case to discuss they were able to identify at least three important components with regard to the setting, style, and content of the discussion of that process, despite having not being specifically taught those points. This is an advantage when teaching these skills to medical students – they have an intuitive sense, partly in reaction to poor role modelling, of the right way to break bad news. Nevertheless there are many aspects of the breaking of bad news that they were not able to intuit and only approximately a third of students could identify the five key components of setting, style and content. The commonest mistake a student made when considering how to break bad news were a failure to understand the importance of discussing with the patient the appropriate timing, setting (eg whether or not they wanted relatives present), and content (did they wish to know the prognosis etc at that time or would they prefer to wait etc). Overall, it was interesting that the process of undertaking that tutorial drew out a lot of their intuitive knowledge regarding the issue and reinforced its importance, rather than providing completely new knowledge.

**Level of comfort** – one of the most surprising findings of this study was the dramatic change in attitude of the students to the notion of students / doctors crying in front patients when bad news is being delivered. Whilst almost half the students had felt like crying in such situations, almost none had done so. Indeed the majority of students felt that it was inappropriate to ever really cry in front of patients, before the tutorial, however following the tutorial the majority of student acknowledged that crying in front of patients sometimes was indeed not inappropriate.

The fact that many medical students struggle with the more poignant aspects of medicine eg dealing with dying patients, is well described and the observations in this study support that. One quarter of the students felt that while the majority of them had a patient cry in front of them, and they described feeling comfortable during that process, the fact that half the students felt like crying at some stage, a quarter felt that because of their empathy with the patient they felt “too soft to be doctors” supports the notion that medical students feel a lot more distress in such situations than is generally obvious. The data in this study does not demonstrate that teaching medical students that it is sometimes “okay to cry” in front of patients is likely to reduce any such feelings, it does support the idea that students may feel more comfortable with dealing with such situations. The fact that 84% of students described an increase in their comfort level in such situations following the tutorial supports that notion. This is also supported by the observation that 97% of students found the tutorials helpful even though there was no objective measurable change in their knowledge level.

When we began this tutorial program thirteen years ago, we did so in the hope rather than the expectation that it would provide training that was helpful in developing medical students communications skills in situations where the breaking of bad news was important. The program was modified progressively over the early years based on student feedback. The effectiveness of this tutorial is principally because it provides an imprimatur for medical students. In the initial years the students were taught by professional clinical psychologists but based on their feedback the program was altered so that clinicians who actually had to give bad news took over the training. Based on student feedback, this is an important component of the imprimatur effect i.e. it avoided compartmentalization of the giving of bad news and communication with grieving patients from psychological / psychiatric areas to routine clinical practice. This imprimatur effect is manifest in several areas. Firstly, it highlights the importance of breaking bad news optimally. It reinforces the notion that this is a skill that can be developed and practiced once the barriers of discomfort are overcome. Changing views on the importance of this skill were not testable in this study because the importance factors were highlighted before the tutorial (the tutorial is compulsory). The second important outcome of the imprimatur effect related to the major problem of student (and doctor) discomfort in dealing with sick and dying patients. The notion that dealing with such patients is a skill to be practiced and that the acquisition of these skills provides a level of comfort in such situations is extremely important. Equally important is the notion that the students / doctors own emotions in such situations do not need to be avoided. When students hear from senior clinicians that it is okay to cry, and that they themselves have cried in front of patients, they become much more relaxed about these otherwise uncomfortable components of such student / doctor - patient interactions.

Not all aspects of this imprimatur effect were testable i.e. the students were not randomised to groups that had been taught by senior clinicians versus non clinical psychologists. Similarly, UMAT – interviewed enrolled students were not compared to those who were enrolled in the traditional ways as this was not possible in our or other medical schools.

One of the medical students who undertook this tutorial was faced with having to deal with a grieving father of an eight year old girl who had been killed in a car accident. Although she was only a week out of medical school, everyone else in the Emergency Department was busy and she was left to talk to him about the death of his daughter. She remembered many things from the tutorial on breaking bad news that she had attended three years previously. She wrote afterwards “ I was about to stand up to leave when I realised that I started to cry and I had to sit down again. I don’t think I could have avoided crying but I was still glad that same University tutor had told us that crying with patients was okay. I really hoped that I hadn’t made things worse. Six weeks later the chaplain rang the hospital wanting to know my name and asking that I be thanked. The letter she wrote to us about that experience and the value of the tutorial participated in three years previously has provided a powerful introduction to that tutorial. The letter can be found at [www.bruceroobinson.com](http://www.bruceroobinson.com) .

In conclusion, this study confirms that fourth year medical students have limited and mostly unsatisfactory experiences of the breaking of bad news, they lack personal confidence and comfort when thinking about being able to break bad news, despite being able to identify many of the basic fundamental skills of the process. A single ninety minute tutorial does not have a profound effect on their knowledge base but markedly increases their level of comfort at the notion of breaking bad news.

Additional details of the tutorial as run in our medical school can be found at [www.bruceroobinson.com](http://www.bruceroobinson.com) etc.

**Have you ever been taught to give bad news?**

No 85%  
Yes 15%

**Have you ever been taught how to talk to grieving relatives?**

Yes 6%  
No 94%

**Have you ever been taught how to talk to angry relatives?**

Yes 3%  
No 97%

**How would you rate your own current ability to give patient's bad news?**

Good	7%
Adequate	38%
Unsatisfactory	42%
Poor	12%

**Have you ever had a patient cry in front of you?**

Yes 66%  
No 34%

**At what stage of the interview did it occur?**

Presenting complaint	16%
Past medical history	8%
Family history	26%
Psycho-social status	23%
Systems inquiry	3%
Management	7%
Prognosis	18%

**How do you rate your current level of comfort in handling emotionally laden situations, such a patients crying in front of you?**

Very comfortable	5%
Comfortable	46%
Uncomfortable	47%
Very uncomfortable	1%

**Have you ever seen a patient told bad news, e.g. that they have cancer?**

No 53%

**If yes, rate the giving of bad news in that situation.**

Excellent	4%
Good	33%
Adequate	37%
Unsatisfactory	17%
Poor	10%

**Have you ever had any personal experience of doctor's giving bad news, e.g. family members or friends?**

Yes 22%  
No 78%

**To what extent do you openly reveal your feelings of fear, anxiety, sadness or embarrassment to friends and / or family?**

Always	6%
Usually	24%
Often	14%
Sometimes/ rarely	55%

**How often do friends and / or family openly reveal such feelings to you?**

Always	4%
Usually	25%
Often	33%
Sometimes/ rarely	41%

**Do you think this course has provided information which will help you improve your ability to give patient's bad news?**

Yes 97%  
No 3%

**Do you believe that it is okay to cry in front of patients?**

	Before	After
Usually	4%	12%
Often	2%	3%
Sometimes	30%	51%
Rarely/never	64%	35%

**How well do you think this course introduced students to the important principles of giving patient's bad news?**

Very well	25%
Well	62%
Average	12%
Not very well	1%

#### **Appendix 10. Outcomes:**

Interestingly, although students have never been specifically how to give bad news they can "guess" the right answers when you give them that opportunity. In fact students quizzed on issues of the right setting, style and content, regarding giving bad news to a cancer patient scored well for this tutorial. This is typical of medical students, who can work out what it is that the examiner wants from them. Not surprisingly therefore, as they had scored so well prior to the tutorial, no significant difference was noted in their scores after their tutorial. What is important is that the students get a chance to talk about these skills which crystallises in their minds the component part of the process and also encourages them that these skills are important and should be used. Indeed a high proportion of the students describe substantial benefit from this tutorial in terms of their up skilling.

By talking about the students own individual ideas and how they would want to have the bad news told to them if it were them they learn about individual differences and how important it is to access those rather than utilise a fixed, immutable method of delivery of bad news.

By learning these skills, students increase their level of comfort with delivering bad news. In fact 84% of students said that they would be more comfortable handling such situations in the future.

Equally importantly, there is a major change in the student's attitude to whether or not they cry in front of patients. Whilst most felt that it was inappropriate to cry usually / often in front of patients when giving bad news and this did not change following the tutorial, there was a major change in the proportion of students who felt that it was no inappropriate to cry on occasions with patients when giving the bad news (x to x).

### **Appendix 11 - Useful phrases :**

Some of the most important outcomes of the tutorial were the student's acquisition of some useful phrases. So often students feel a certain way but do not know the words to use. Here are some of the key phrases taught:

#### **What to say:**

Mr Jones, I am sorry to say that it is actually a cancer.

I am sorry that the diagnosis did not turn out better for you.

Although you will be going off to other doctors, I want to reassure you that I will continue to be your doctor and will be there for you throughout your illness.

Some clichés are good clichés “This must be hard for you” etc. “Is there anything that frightens you about this illness?”

Most patients find that planning for the worse but hoping for the best is a good strategy (Explain this).

#### **What not to say:**

It could have been worse. We all have to die sometime.

Any words when silence is required.

### **Appendix 12. Breaking bad news – Web Resources**

#### *Some useful websites [amongst many]*

<http://depts.washington.edu/bioethx/topics/badnws.html>

<http://www.wikihow.com/Break-Bad-News>

<http://www.anzca.edu.au/fellows/sig/welfare/review-rd10-breaking-bad-news.html>

<http://theoncologist.alphamedpress.org/cgi/content/full/5/4/302>

<http://www.racgp.org.au/AM/Template.cfm?Section=General07&Template=/CM/ContentDisplay.cfm&ContentID=23852>

<http://www.skillscascade.com/badnews.htm>

<http://www.aafp.org/afp/2001/1215/p1975.pdf>

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