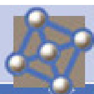

EDUCATION FOR HEALTH

BRIEF COMMUNICATION

Interns' Perspectives about Communicating Bad News to Patients: A Qualitative Study

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ABSTRACT

Introduction: Communicating bad news to patients and families is an essential skill for physicians but can be difficult for interns. Very little is known about skills in this area for interns in developing countries.

Method: Two focus groups, consisting of a total of 12 interns were conducted in the Seth G.S. Medical College and KEM Hospital in Mumbai, India. The grounded theory approach was used to identify common themes and concepts, which related to: (1) barriers in communicating bad news, (2) interns' confidence in communicating bad news, (3) interns' perceptions about their need for such training and (4) interns' suggested methods for training.

Results: Interns described barriers in time constraints, language, their personal fears, patients' illiteracy, crowded wards with no privacy and lack of training. All interns lacked confidence in breaking news of death, but seven were confident in breaking bad news about chronic diseases or cancers. Subjects reported they had received very little classroom teaching or formal instruction in this area, though they had had opportunities to observe a few instances of breaking bad news. They expressed need for increased focus on communication skills curriculum in the form of case discussions, workshops and small group teaching, in addition to clinical observation.

Conclusions: Interns in our school in Mumbai reported inadequate training and low comfort and skill in communicating bad news and expressed need for focused training.

Keywords: Breaking bad news, communication barriers, Medical education.

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Introduction

The medical education system in India is one of the largest in the world. It has a five and half year curriculum with the three-phase framework of pre-clinical (12 months), para-clinical (18 months) and clinical (24 months), plus an internship (12 months). Interns are expected to assume significant responsibility for patients care during their clinical postings, including being able to confidently communicate with patients and their family members.

Poor communication of end-of-life matters by interns is all too common[1] and has been shown to be associated with poor patient-care outcomes, including inadequate pain and symptom relief[2] delivery of unwanted care, and conflicts between physicians including vandalizing hospitals and nursing homes within India[3]. Although there is some training in the West for medical students regarding breaking bad news[4,5] , assessment of skills in breaking bad news is not commonly done. In India, there is no formal training in communication for end-of-life issues, including breaking bad news.

These issues were explored with a qualitative design using focus groups. Subjects were 2009 Interns of the Seth G.S. Medical College in Mumbai, India.

Methods

Permission was obtained from the dean of the institution to conduct two focus groups of six members each. Interns were randomly selected from the class and had completed 11 months of a rotating internship at the time of the interviews. The interns were informed at the beginning of the session that their perspectives would be used for a published paper and anonymity would be maintained. A guide for conducting focus groups was developed to explore interns' perspectives about communicating bad news. Data was kept confidential and anonymous. A senior faculty member conducted focus groups. Focus group interviews were conducted in English and were audio taped. They were later transcribed verbatim.

Qualitative data analysis was done using a grounded theory approach with constant comparative analysis, a process of reading and re-reading the narrative data, developing categories of responses in the process, and then reviewing previously read data to check the appropriateness of the categories developed[6]. Two reviewers independently coded transcripts and developed the categories. An inductive content analysis of all the comments was done[7,8]. Categories of similar issues within the comments were identified and coded. Inter-rater reliability of identified categories and comments assigned to categories, were calculated using Miles and Huberman's formula[9] as follows: Reliability = number of agreements/total number of agreements and disagreements. The reviewers resolved all differences in coding through consensus. To ensure trustworthiness of the qualitative data analysis, criteria for trustworthiness recommended by Barzansky[10] were applied. Comparisons of category assignments were made between the two reviewers, and three interns who had participated in the focus groups did a member check to help ensure that the categories accurately captured all important issues. The issues, with illustrative quotes, are described in detail in the results section.

Results

By organizing associated concepts into unifying categories, a framework of the findings was developed. This framework consisted of four major categories corresponding to the questions posed to students, six sub categories and 27 specific issues.

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Category 1: Perceived barriers to communicating bad news to patients and families

Sub categories: Institutional, Patient and Interns factors.

Institutional factors

Interns described time constraints due to an overload of work and time pressures. '*The way our system works we do not have time to take 10 minutes and have a tea, and also to grieve for the losses of our patients regardless of how brief the contact or settings is. One understands that this is needed but does not have time*'.

The second related theme was the crowded wards. '*Demand for indoor admissions is high. Hence there is crowding of wards and rapid turnover of patients. Hence rapport is not developed . . .*'

The third related theme was lack of privacy and space for talking to patients and their relatives. Interns commented: '*Another barrier is privacy. Ward is full of 50 patients and double the number of relatives looking at our conversation – How I am going to communicate with them?*'

Patient factors

In India, many patients are not able to understand the doctor's language and the illiteracy rate is high amongst patients. Interns find it difficult to adapt to the low health literacy level of patients in their communications.

> '*One would consider main barrier as literacy level of patient. The second is how much relatives are aware of the disease.*'

> '*Many patients only understand local language and interns come from all over country. Though we try to learn local language, there is always difficulty in communicating bad news especially in special situations*'

The second patient-related theme is the mental condition of the patient and the emotionality associated with the situation. '*One needs to consider mental makeup of patient . ..*'

Intern factors

Interns noted the importance of their fear and perceived inability to handle the situation.

> '*Revealing bad news is a difficult task itself. This is because you are not prepared for this, as well as patient or his/her relatives are not prepared for it. There is no formal training about this in our UG [undergraduate] education. It is difficult to make a decision to know how to go about this.*'

Category 2: Strengths and limitations of current curriculum

The first subcategory was perceived lack of a formal curriculum in training students and interns to communicate bad news. Interns commented: '*We are generally taught about what to take in history and examination but not taught how to communicate bad news. There is no formal curriculum*'

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Another subcategory that was identified by students was the non-uniform or even randomness of their experiences in communicating bad news. Interns commented:

> '*Random process – everyone does not get uniform experiences – One may get an opportunity; other may not get opportunity to observe or learn. The strength of our curriculum is that it has many opportunities for experience – one is put to test in such situations – and on the job experience or practice such skills*.' and '*We normally learn randomly by trial and error. First time you do it you must do it under supervision*'

Category 3: Suggested teaching and learning strategies for improving skills in communicating bad news to patients and relatives

During the focus groups interns expressed clear suggestions for how to improve their delivery of bad news within a hospital setting. The majority of the interns suggested various teaching and learning strategies that would emphasize the most appropriate manner in which to deliver news, depending on the context of the situation. All interns felt a definite need for introducing formal curriculum for communicating bad news. The strategies that were suggested were: introduction of a formal curriculum, interactive sessions, role-play, practical demonstrations and practice with reflective feedbacks.

The majority of interns believed that theory-based lectures were less useful than practical experiences with opportunities for practice and feedback. The interns also suggested that direct observation of staff physicians was helpful but that there needed to be more opportunities to process their interactions, to ask questions and receive staff feedback after the news had been delivered.

Category 4: Other suggestions

During focus group interviews, interns made other useful suggestions. They emphasized the need for improving overall communications skills training in the current curriculum. One of the interns suggested more emphasis on communication skills during summative assessments.

Other suggestions expressed by interns were to extend this training to other health professional staff and improve the institutional infrastructure to provide dedicated space for counseling in each ward. There were also suggestions to reduce workload (by restricting work hours) to improve the quality of service provided to the community.

Discussion

This study highlights the limitations of our school's current curriculum in helping graduates develop competence in communicating bad news, especially death-related. All interns were uncomfortable with communicating bad news in these situations. The results of this study confirm deficiencies in the curriculum, which may not be different from that of other schools in India, resulting in interns being uncomfortable in communicating bad news. Interns cited time constraints, overcrowding and lack of space and privacy as being the main institutional barriers. These factors make it difficult to appropriately delivery bad news and interfere with delivering health care, such as assisting family members as they view the deceased patient.

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Findings from the study indicate that our interns are willing to learn communications skills in order to improve their clinical encounters. The study further supports the need for a formal curriculum in this area during the undergraduate program and internship. Interns felt that interactive sessions such as role-plays, one day workshops and feedback should be included in the curriculum to help them learn how to break bad news.

Limitations

The study does have some limitations. It was conducted at only one institution and included participants of only one intern class. Experiences of students may be institution-specific, and the subset of students surveyed in this study may not be representative of all interns at this institution. However, due to the diverse nature of the surveyed students, we believe that the study does provide insights that can be used broadly to improve the undergraduate curricula to address student needs and goals for communicating bad news to patients and families.

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