Medical Students' Perspectives in Relation to Delivering Bad News to Patients

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### I and other authors of this article titled “Medical Students' Perspectives in Relation to Delivering Bad News to Patients” declare that there is no conflict of interests regarding the publication of this article.

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**Abstract**:

Undoubtedly, breaking bad news is one of a doctor’s most difficult duties. Not having this skill and not paying attention to its details can result in poor patient satisfaction, psychologic morbidity, and poor treatment decisions.A cross-sectional study was conducted using a questionnaire administered to all medical students of Qom University of Medical Sciences, Iran. 269 of 310 students responded to this survey (86.8% response rate). The questionnaire was designed and validated by three medical ethics specialist.54.4% of students believed that delivering bad news to patients depends on the patient's compliance and condition. 55.8% of the participants believed that patients’ family should be the first recipient of the bad news. 47.6% of students also said that they did not receive training about breaking bad news.Breaking bad news is a balancing act that requires doctors to adapt continually to different factors. Although most of the medical students were keen to help their patients, they lacked the essential knowledge and skills for breaking bad news. Development of strategies and guidelines to improve societal views, and train physicians about breaking bad news, is needed.

**Keywords**: Breaking bad news; Medical Ethics; Empathy; Medical Education; Medical Student

**Introduction:**

Maybe no encounter between the doctor and the patient is more stressful than one in which bad news is given (1). Delivering bad news is difficult for doctors and medical students (2). All doctors will be forced to report worrying news about their patient's health over their lifetime, which may cause concern and discomfort to the patient, such news is called bad news (3).

Although, based on reports, most doctors are satisfied with their profession, it seems that this profession is associated with high levels of stress (4). One of the common stresses of this profession is the relationship with the patient, and especially the delivering of a bad news (5). In addition, if the bad news transfer correctly is could relieve the patient's pain (6). On the other hand, the inaccurate communication of one, is the common cause for patients to complain against doctors (7).

Some patients blame the doctor in response to bad news. This false negative attitude towards physicians who transmit bad news is understandable, as many of them do not use the correct way to transmit bad news (8).

In addition to cultural differences, many other factors also affect the judgment of the physician about delivering bad news (9). The most important reason is the lack of familiarity of the physician with the best way to deliver bad news, the fear of an individual's failure experience, lack of understanding of the patient's mood and affection, fear of emotional response to the patient, and lack of knowledge of what might happen (10).

Lack of training, leads to behaviors that are communicatively unessential and non-scientific, doctors need to be trained to gain this skill, because they are responsible for transmitting bad news (11).

First and the most important obstacle to the transmission of bad news is lack of skills and training about it, which requires the beginning of training in medical schools (12).

Appropriate training on how to transmit bad news, can reduce discomfort and the uncertainty that usually occurs during delivering bad news (13).

The lack of prior training about delivering bad news, even in some experienced physicians, can reduce significantly the health and the satisfaction of both patients and health care professionals (14).

Considering the importance of the research mentioned above, in this study, by studying the perspectives of students towards how bad news is delivered to the patient, it is possible to plan this important issue among students. Therefore, the present study was conducted to investigate the medical students' perspectives in relation to delivering bad news to patients.

**Methods:**

This cross-sectional study was conducted on all the medical students, in one teaching university located in an urban area of Iran, 2015. All medical students were asked to participate in the survey and decision as to whether or not to take part in this study was completely voluntary. From 310 medical students, 41 of whom were excluded from the study due to absence or unwillingness to cooperate. Finally, 269 medical students participated in the study.

The data gathering tool was a questionnaire. In addition to the demographic information, the questionnaire included 20 questions about breaking bad news and its aspects. The questions were formulated by the authors based on a review of literature published on breaking bad news. The questions validated by ten medical ethics specialist.

SPSS version 18.0 was used to analysis data.

All participants were asked to give verbal informed consent. Data were collected on questionnaires without recording any identifiable information. The University Ethics Committee Review Board approved the study protocol.

**Result**: The mean age of participants was 21.3±2.4 years. One hundred seventy five out of a total of 269 medical students (65.1%) were female. Baseline characteristics of the participants are detailed in Table 1.

Table 1: Baseline characteristics of the study population

|  |  |
| --- | --- |
| Characteristic | All participant (n = 269), number (percent) |
| Age group  18-20  21-25  26-30 | 117 (43.5)  142 (52.8)  10 (3.7) |
| Sex  Male  Female | 94 (34.9)  175 (65.1) |
| Level of training  Basic Science (First to fifth semester)  Introduction to Clinical Medicine (Sixth and seventh semester)  Stager (Eighth to eleventh semesters)  Internship (Last three semesters) | 153 (56.9)  28 (10.4)  67 (24.9)  21 (7.8) |
| Marital status  Single  Married  Divorce  Widow or widower | 225 (83.6)  43 (16)  1 (0.4)  0 |
| Birth place  Native of the province  Other province | 147 (54.6)  122 (45.4) |

46.8% of participants believed that the patient should be informed about her untreated illness; however, the 7.8% were disagree to this topic and 45.4% believed that the decision in this topic depends on the patient's adaptive compliance. Medical students' perspectives in relation to how to delivering bad news are detailed in Table 2.

Table 2: medical students' perspectives in relation to how to delivering bad news

|  |  |
| --- | --- |
| Questions | No. (%) |
| 1. Who should be the first person to receive bad news?  Patients  Patients’ family  Patients’ friend  Based on patient decision | 53 (19.7)  150 (55.8)  35 (13)  31 (11.5) |
| 2. Who should be the first person to deliver bad news?  Physician  Nurses  Counselor  Physician or counselor  Physician or Nurses  Nurses or counselor | 146 (54.3)  11 (4.1)  20 (7.4)  83 (30.9)  7 (2.6)  2 (0.7) |
| 3. About bad news transmitter behavior  Formal behavior without expressing emotions  Along with sympathy  No difference | 43 (16)  212 (78.8)  14 (5.2) |
| 4. About bad news place  Clinical setting  Out of clinical setting  No difference | 174 (64.7)  56 (20.8)  39 (14.5) |

44.6% of medical students believed that bad news should be delivered to patient along with hope; however, only 3.7% believed that it should be delivered without hope. Medical students' perspectives in relation to what to deliver about bad news are detailed in Table 3.

Table 3: medical students' perspectives in relation to what to deliver about bad news

|  |  |
| --- | --- |
| Questions | No. (%) |
| 1. The first issue to be said during the delivering of the bad news  The course of the disease  Patient's clinical condition  Information on available treatments | 87 (32.3)  90 (33.5)  92 (34.2) |
| 2. The need for medical records and paraclinical results  Should not be presented  Just in case aid should be provided  Should not be presented based on the level of awareness of the information recipient  Should be presented | 23 (8.6)  82 (30.5)  119 (44.2)  45 (16.7) |
| 3. Hope for the patient  Either way, with hope  Either way, without hope  If the patient's clinical condition is hopeful  If the listener needs hope | 120 (44.6)  10 (3.7)  68 (25.3)  71 (26.4) |
| 4. Transmission detail of disease and patient status  Should not be transferred  Details must be fully transmitted  Should not be transferred based on patient cooperation  No difference | 24 (8.8)  47 (17.5)  185 (68.8)  13 (4.8) |

Medical students were asked about education in delivering bad news (Table 4). 47.6 % of interns had not received any education for delivering bad news.

Table 4: medical students' perspectives in relation to education about delivering bad news

|  |  |
| --- | --- |
| Questions | No. (%) |
| 1. Have you ever received any education for “delivering bad news”? (For internship participants (n=21))  Yes  Received incomplete education  No | 3 (14.3)  8 (38.1)  10 (47.6) |
| 2. What is the best way to teach bad news  Teaching Theory  Training by holding a workshop  Clinical training  No difference | 14 (5.2)  82 (30.5)  160 (59.5)  13 (4.8) |

**Discussion:**

In this study, we have attempted to evaluate perspective of medical students in relation to breaking bad news.

45.4% of students believed that delivering bad news to patients depends on the patient's compliance and condition. 46.8% of participants believed that the patient should be informed about her untreated illness.

In a study by Leppert et al. on 401 medical students and 217 physicians who reported on the attitude of medical students and physicians about reporting bad news, 35% of participants stated that they could act on the transmission of bad news, depending on the patient's condition (2). The similarity between the results of the two studies shows that a large number of students are aware of the importance of patient conditions during the transmission of bad news. In Iran, a study by Kazemi et al. on 200 physicians showed that 20% of doctors believed that the patient should be informed about the diagnosis of a disease that can lead to death (15).

About the first receptor of bad news, 55.8% of participants believed that patients’ family and 19.7% believed that patients should be the first recipient of bad news.

In Leppert study, 28 percent of doctors and 32 percent of students believed that the first bad news recipient should be patients’ family, but the others believed patient should be the first recipient of bad news (2). This difference between the study of the Poland and Iran can be due to the difference in the role of the family in the two communities, because in the eastern societies and particular in the Islamic societies, the family has a more important role than western societies. The close relationships between family members in eastern societies, provides greater recognition of family members, and the family may be able to provide more favorable conditions for transmitting bad news to the patient.

About the first person to deliver bad news, 54.3% of participants believed that physician and 30.9% believed that physician or counselor should be the person to deliver bad news. It seems that most students believe that the best provider of good news is a doctor. In a study by Managheb, 65.6% of patients believed that best person for transmission of bad news, is physicians (16). In a study by Jurkovch et al. 57% of patients said that they received bad news from a doctor (12).

About the first issue to be said during the delivering of the bad news, 34.2% of participants selected “information on available treatments”, 33.5% selected “patient's clinical condition” and 32.3% of participants selected “the course of the disease”. It seems that most participants in the study tend to start with an introduction.

In this study, most students believed that bad news transmitter behavior should be accompanied by sympathy that these results reinforce the importance of the Empathy component of the SPIKES protocol, which is used to transmit bad news (17).

64.7% of medical students stated that it would be better to delivering bad news in Clinical setting. In the Illingworth study in the United States, most American doctors believe that hospitals is a more appropriate place to provide information to the patient (18). However, In a study by Mangibe et al., 50% of the patients disagreed with the breaking bad news in the corridor, and 64% of the patients disagreed with the breaking bad news in the emergency room (16), which is a difference with physicians opinion, patients prefer to hear bad news in a private room (16).

About the best way to teach bad news, 59.5% of medical student selected clinical training and 30.5% workshop training.

In a study by Kiluk JV et al. in the United States, the clinical experience of medical students about break bad news significantly increased after a clinical training course (19).

38.1% of interns said they received incomplete education about the breaking bad news and 47.6% said they had not received any education. These results have been consistent with many similar studies conducted on different groups of health care personnel, especially within Iran (16, 20). While studies in other countries show better statistics (21). Due to the complexity of the breaking bad news, the elaboration of an accurate educational curriculum, with regard to the cultural, religious and economic conditions of the community is essential.

**Conclusion:**

Breaking bad news is a balancing act that requires doctors to adapt continually to different factors. Although most of the medical students were keen to help their patients, they lacked the essential knowledge and skills for breaking bad news. Development of strategies and guidelines to improve societal views, and train physicians about breaking bad news, is needed.

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