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Breaking bad news: experiences, views and difficulties of pre-registration house officers

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Objectives: To obtain information regarding the involvement of pre-registration house officers (PRHOs) in the discussions on bad news, and the competency and difficulties they perceive in clinical practice. **Design**: Structured telephone interviews. **Participants**: 104 PRHOs. **Main outcome measures**: Information about frequency and quality of involvement of PRHOs in discussions on bad news with patients and relatives, perceived competency and difficulties related to this task as well as ethical views concerning the disclosure of bad news. **Results**: 82 PRHOs (78.9%) had initiated the breaking of bad news to a patient at least once, whilst patients themselves had initiated discussions of bad news by asking the doctors questions (92.3%). Almost all (96.2%), indicated that they had broken bad news to relatives of a patient. The majority of the junior doctors participating in our study felt fairly or very confident (90.4%) to break bad news. 'Often' quoted difficulties for over a fifth of the sample included 'Thinking I was not the appropriate person to discuss the bad news', 'Having all the relevant information available', 'Dealing with emotions of patient/relative', 'Lack of privacy' and 'Patients/relatives do not speak English'. Although 99 PRHOs (95.2%) believed that patients should be informed about a serious life threatening illness, 30.8% of the participants stated that doctors need to judge whether or not to tell a patient bad news. Factors most frequently selected by the PRHOs from a given list of possible factors contributing to a gap between theory and practice included problems with the organization of clinics (73.1%), insufficient postgraduate training (63.5%) and lack of staff (54.8%). **Conclusions**: The results indicate that PRHOs are frequently involved in the breaking of bad news. Whilst no claims can be made for their actual performance in practice, their perceptions of competency would indicate that the extensive and compulsory undergraduate teaching they had received on this subject has served to prepare them for this difficult task. Organizational and structural aspects need to be taken into account as factors assisting or undermining doctors in their efforts to put into practice ethically sound and skilled communication when disclosing bad news. *Palliative Medicine* 2005; **19:** 93–98

Key words: breaking bad news; difficulties; ethical standards; experiences; pre-registration house officers; views

Background

Breaking bad news is a difficult task frequently performed by doctors in most specialities.[1,2] The needs of patients and the difficulties health care professionals face when breaking bad news, as well as the effects of training sessions on communication skills have been areas of interest for research during the last decade. Empirical studies show that patients want to be informed about a serious life threatening illness.[3,4] Physicians acknowledge the right of patients to be informed in these situations,[5] however, most of them never have received formal training to support them in this task.[1] Key communication skills considered to be important in the context of breaking bad news have been identified[1,6] and there is increasing evidence that the skills necessary to break bad news in a patient-centred manner can be acquired in

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courses using experiential teaching methods.[7,8] In addition, data from clinical studies indicate that good communication skills can contribute significantly to health and to satisfaction of both patients and health care professionals.[9,10]

Clinicians are confronted at an early stage of their career with difficult communication situations related to the care of seriously ill and dying patients[11] and many junior doctors do not feel sufficiently prepared for these tasks.[12–14] Following the recommendations of the General Medical Council (GMC) in 'Tomorrow's doctors'[15] the curricula of many British medical schools now include courses on breaking bad news.[16] There is evidence that these teaching sessions improve the self-perceived competency of medical students.[17] However, the extent to which such specific training in undergraduate courses has sufficiently prepared young doctors at the beginning of their professional career when facing the task of imparting bad news remains unanswered. Research in this field is warranted for several reasons. First of all data about the involvement of junior doctors in discussions on bad news provide insight about current clinical practice and thereby informs the debate about ethical standards. Secondly, the results about perceived competency may serve as an indicator for the outcome of the recent changes in undergraduate teaching that is costly in terms of financial and personal resources. Finally, the identification of potential difficulties and educational needs informs the planning of undergraduate as well as postgraduate teaching about breaking bad news.

In this study we interviewed pre-registration house officers (PRHOs) at the end of the first year of their professional career about their experiences, perceived competency and ethical views with respect to breaking bad news. All PRHOs are graduates from one London medical school who have received a substantial amount of teaching on breaking bad news in communication skills as well as ethics and law applied to medicine. This included interactive lectures, experiential learning using training videos, role-plays, simulated patients and small group discussions.[17] The aims of the study were to:

- Elicit the extent of PRHO involvement in the process of breaking bad news and to gather information about any postgraduate education they had received on this aspect of clinical practice.
- Identify their perceived competency and difficulties when breaking bad news to patients or relatives.
- Identify their views regarding ethical aspects of breaking bad news and any perceived differences between the content of the training and clinical practice.

Methods

In June 2003 two research assistants contacted, via the switchboard, all 139 former students who had graduated in 2002 and had started to work as PRHOs in one of the hospitals affiliated to the medical school. The research assistants were not involved in any of the teaching activities for the former students. In accordance with the approval of the local research ethics committee the interviewers first explained the purpose of the survey. Confidentiality was assured. PRHOs willing to participate in the study were asked to give verbal informed consent. Data were collected on questionnaires without recording any identifiable information. The questions were formulated by three of the authors (JS, AC and LD) based on a review of literature published on breaking bad news.[8] Whilst recognising that many different situations are experienced by the patient as bad news, for the purpose of this investigation we defined bad news at the beginning of the interview as a 'serious life threatening illness'. The questionnaire contained 41 items which were formulated either as closed-ended multiple choice questions or as statements. In the latter case respondents could indicate their (dis-)agreement with the statement on a five-point Likert scale using 'strongly agree' to 'strongly disagree' as the extreme points of the scale. To validate the questionnaire test interviews with PRHOs who had graduated from other medical schools were undertaken as a pilot. Minor changes were made as a result of these interviews.

Results

Six of 139 PRHOs who appeared on the list as trainees in one of the hospitals affiliated to the medical school were not in post. 104 PRHOs were willing to participate in the study. The response rate was 104 out of 133 PRHOs who had graduated in 2002 from the medical school (78%), of whom 43.3% were male and 46.2% female. In 11 cases the gender of the PRHOs was not recorded. The average age was 25.6 years (minimum: 23 years, maximum: 33 years).

With one exception all PRHOs had participated in sessions on breaking bad news as part of the undergraduate curriculum and had experience with role plays and simulated patients. As part of their postgraduate training two PRHOs received teaching sessions on breaking bad news including role plays, 17 had attended lectures and 13 had attended grand rounds on this topic. With one exception, all junior doctors had observed discussions on bad news between more senior doctors and patients during their year as a PRHO.

Table 1 provides detailed information regarding the involvement of PRHOs in breaking bad news. 82 PRHOs

Table 1 Frequency and type of tasks performed by PRHOs with respect to breaking bad news

	Initiating breaking of bad news to a patient (%)	Discussing bad news as a result of the patient asking questions (%)	Discussing bad news with a relative (%)
No	21.1	7.7	3.8
Yes, once	12.5	8.7	4.8
Yes, 2–5 ×	45.2	47.1	48.1
Yes, 6–10 ×	13.5	23.1	26.0
Yes, >10 ×	7.7	13.5	17.3

(78.9%) had initiated the breaking of bad news to a patient at least once whilst 92.3% of PRHOs said patients had initiated discussions of bad news by them asking. Almost all, 100 (96.2%), indicated that they had broken bad news to relatives of a patient.

The majority of the junior doctors participating in our study felt fairly or very confident (90.4%) to break bad news (Figure 1). Table 2 gives an account on problems perceived by PRHOs when discussing bad news. 'Often' quoted difficulties for over a fifth of the sample included 'Thinking I was not the appropriate person to discuss the bad news', 'Having all the relevant information available', 'Dealing with emotions of patient/relative', 'Lack of privacy' and 'Patients/relatives do not speak English'. With the exception of 'Dealing with patients/relatives emotions' these factors were also quoted as 'Sometimes' difficult for over half the rest of the sample. Additionally, over half of respondents sometimes found 'Handling uncertainty', 'Dealing with my own emotions' and 'Judging how much information people want' to be a problem. Over half of the sample stated they never found 'Use of non-medical terminology' and 'Being honest with patients/relatives' a difficulty.

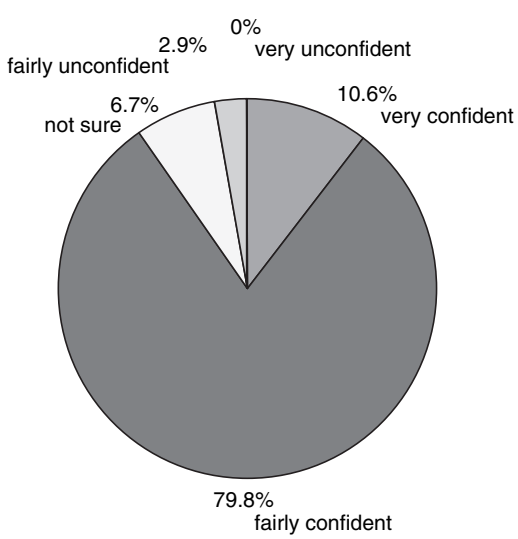

Figure 1 Level of confidence to break bad news as perceived by PRHOs ($n = 104$).

Figure 2 summarizes the views of the participants in this study concerning ethical aspects of breaking bad news. Although 99 PRHOs (95.2%) believed that patients should be informed about a serious life threatening illness, 30.8% of the participants stated that doctors need to judge whether or not to tell a patient bad news. Most (94.2%) disagreed with the statement that doctors should follow the wish of relatives not to inform a competent patient about bad news. Just over half (57.6%) of the junior doctors viewed guidelines or protocols as helpful with respect to breaking bad news. The majority (81.7%) disagreed with using euphemisms for words like cancer.

According to the observations, the PRHOs doctors were 'often' ($n = 67$; 64.4%) or 'always' ($n = 24$; 23.1%) honest with their patients whilst 11 (10.6%) stated that this was only 'sometimes' the case. When asked whether bad news was communicated in an appropriate and private environment 35 PRHOs (33.7%) thought this was 'often' or 'always' the case, a further 39 (37.5%) said this was 'sometimes' the case whereas 28 (27.0%) stated this 'rarely' or 'never' took place in such an environment.

The gap between the undergraduate teaching in ethics and law and the practice of breaking bad news as experienced during their year as a PRHO was thought to be medium by 41 respondents (39.4%), large by 12 (11.5%) and very large by 5 (4.8%).

Factors most frequently selected by the PRHOs from a given list of possible factors contributing to a gap between theory and practice (Table 3) included problems with the organization of clinics or wards (73.1%), insufficient postgraduate training (63.5%) and lack of staff (54.8%). Lack of high priority given to ethically acceptable practice in clinical practice was not thought to be a cause by 82.7% of the doctors.

Conclusions

In this study we have attempted to follow up the effects of undergraduate teaching sessions in communication skills and ethics and law applied to medicine from the perspective of doctors at the end of the first year of their professional career. Given the good response rate (78%) the results can be interpreted as representative of the experiences and views of the PRHOs who graduated in 2002 from one London medical school and who had received core training on communicational, ethical and legal aspects of disclosing bad news to patients. Findings from this study cannot necessarily be extrapolated to graduates from other medical schools in Britain. As with all questionnaire data, some caution is needed when interpreting findings about behaviour. Respondents may interpret questions differently. Moreover, perceptions and reported behaviour are subjective and no conclusions can

Table 2 Frequency with which PRHOs identified difficulties when talking about bad news in the following categories

	Often (%)	Sometimes (%)	Never (%)	Not appropriate (%)
Having all the relevant information available	24	64.4	10.6	1.0
Use of non-medical terminology	9.6	34.6	54.8	1.0
Allowing for pauses	2.9	67.3	9.6	1.0
Dealing with emotions of the patient/relative	22.1	66.3	9.6	1.0
Handling uncertainty	11.5	57.7	29.8	1.0
Dealing with my own emotions	5.8	59.6	33.7	1.0
Being honest to patients/relatives	9.6	33.7	55.8	1.0
Thinking that I was not the appropriate person to discuss the bad news	28.8	57.7	12.5	1.0
Lack of privacy	28.8	40.4	29.8	1.0
Judging how much information people want	17.3	59.6	22.1	1.0
Patients/relatives do not speak english	21.2	51.9	26.0	1.0

be drawn from the data of perceived competences about actual performance in situations. Nevertheless some interesting results emerge that have implications for designers and deliverers of education.

The results indicate clearly that PRHOs are frequently involved in the process of breaking of bad news. They therefore do need training in this important clinical task before they graduate. For the purpose of this study bad news was defined as 'a serious life threatening condition'. It is possible that even more PRHOs have disclosed bad news about conditions other than those that are life threatening.[18] Compared with previous studies the doctors taking part in this study seem to evaluate their competency with respect to breaking bad news positively.[12,13] The perception of improvement in communication skills is often used as an indicator to evaluate the effect of teaching sessions on breaking bad news[8,19] based on the theory that self-efficacy or confidence is a factor influencing behaviour.[20] These findings suggest that the extensive and compulsory undergraduate teaching in communication and ethics has been positive in ensuring that PRHOs do not feel unprepared to address this issue with patients and relatives. It is obviously not possible to comment on their actual competency in discussing bad news and they may well be over or under estimating their performance. Research methods involving observation and rating of performance in the context of everyday clinical practice

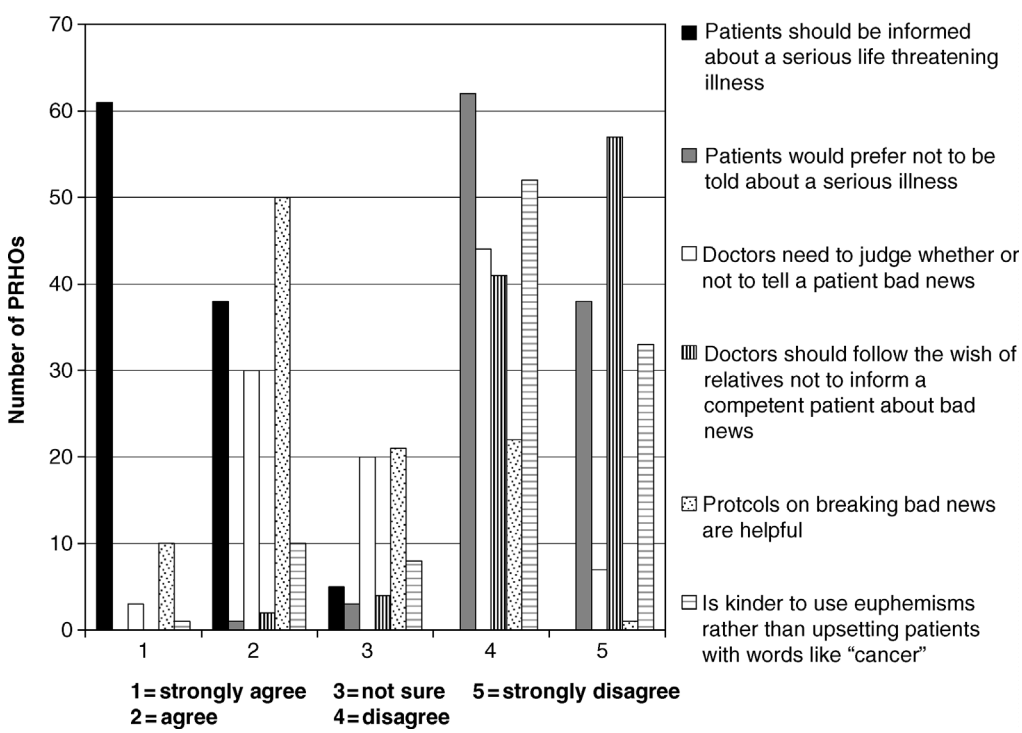

Figure 2 Views of PRHOs on good practice of breaking bad news.

Table 3 PRHO's views on factors contributing to a perceived gap between teaching and practice of breaking bad news

	Yes (%)	No (%)	PRHOs not perceiving a gap (%)
An ethically acceptable practice does not have a high priority in clinical practice	12.5	82.7	4.8
Ethical standards are unrealistically high	25.0	70.2	4.8
Insufficient undergraduate training	10.6	84.6	4.8
Insufficient postgraduate training	63.5	10.7	4.8
Lack of staff	54.8	40.4	4.8
The way clinics or wards are organized	73.1	22.1	4.8
Lack of medical knowledge	47.1	48.1	4.8
Poor team-work	30.8	64.4	4.8

would be necessary to provide more objective data about what actually happens and such methodology presents considerable problems particularly with this subject.

Almost all of PRHOs taking part in this study agreed that patients should be informed about their condition and rejected the idea that physicians should follow the wishes of relatives not to inform their patients. However, there was an apparent discrepancy insofar as a third did think doctors should decide whether to tell bad news to a patient. Whereas the GMC guidelines on good practice[21] accept that there are situations when it may be ethically acceptable to withhold information to avoid serious harm for the patient, the challenge for doctors is how to assess this. In clinical practice any decision about non-disclosure made by the clinician should be made in the light of the values and interests of the patient and their choice ultimately to know or not to know. This may be a particularly difficult task for inexperienced junior staff. Notwithstanding a good grounding in skills and attitudes, situations in clinical practice are complex and demand judgements based on sound ethical principles.

The PRHOs in this study were almost all talking to relatives about bad news thus highlighting how liaison with relatives is an important task that PRHOs perform. This again is a particularly difficult task for doctors to manage in protecting patients' rights to information whilst recognising the concerns and managing the expectations of relatives. Further postgraduate training could help to address some of these complex situations.

PRHOs trained in accordance with the current good practice guidelines may be sensitive to any gaps between what they have learned and what occurs in clinical practice. The PRHOs did for the most part think that the perceived gap was due to a lack of staff, lack of space for privacy and problems with organization of clinics and wards which all affect the quality of discussions on bad news. These findings are consistent with results from an earlier study among PRHOs about their perception of the practice of informed consent[22] and underline the importance of resources and organizational aspects for ethically acceptable practice.[23]

The lack of medical knowledge and insufficient postgraduate training were also perceived to be problems by the PRHOs and the finding that only a small proportion had participated in postgraduate teaching sessions indicate a need for further, task specific, postgraduate educational sessions on difficult professional tasks.[24] Many qualified doctors would benefit from training since most of them have never received educational sessions on bad news whilst at the same time they act as role models for their younger colleagues and thereby influence actual clinical practice.[6,25] Last but not least it has to be taken into account that organizational and structural factors can either assist or undermine doctors in their efforts to put into practice ethically sound and skilled communication when disclosing bad news. Given that organizational factors and work pressures make it hard to maintain the highest standards which we are teaching undergraduates to aim for, there needs to be both a recognition of these constraints, efforts to change those which could be changed and opportunities for postgraduate education to build upon the undergraduate teaching and to address the situations of bad news that doctors are now dealing with. In the UK the GMC makes such recommendations for PRHO training in its document 'The New Doctor'.[26] Such improvement in the areas mentioned should help to ensure professional proficiency and good quality of care for patients and relatives facing the difficult situation of a serious illness.

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