Published in final edited form as:

J Cancer Educ. 2012 June ; 27(2): 277–280. doi:10.1007/s13187-012-0312-9.

Teaching Medical Students How to Break Bad News with Standardized Patients

John V. Kiluk,

Department of Oncologic Sciences, Moffitt Cancer Center, University of South Florida College of Medicine, Tampa, USA. H. Lee Moffitt Cancer Center, 12902 Magnolia Drive, MCC Br- Prog, Tampa, FL 33612, USA

Sophie Dessureault, and

Department of Oncologic Sciences, Moffitt Cancer Center, University of South Florida College of Medicine, Tampa, USA

Gwendolyn Quinn

Department of Oncologic Sciences, Moffitt Cancer Center, University of South Florida College of Medicine, Tampa, USA

John V. Kiluk: John.Kiluk@moffitt.org

Abstract

One of the biggest challenges that a physician will face is conveying difficult news (CDN) to a patient. The ability to provide this information may either strengthen or destroy the patient–physician relationship. Despite the importance of this skill, formal education for medical students has been limited. To improve upon skill building in the medical student experience, fourth year medical students (on their oncology clerkship) spent 3 hours partaking in a CDN session. During this session, each student had a videotaped encounter with a standardized patient, followed by a small group discussion and review of the tape with other students and a clinician. We evaluated the experience with pre- and post-questionnaires assessing overall knowledge, satisfaction, and specific components of the curriculum. The objective of this study was to review our institution's educational program focused on teaching techniques for CDN.

Physicians will face many challenges but one of the most difficult will be conveying difficult news (CDN) to a patient or family member. The ability to provide this information may either strengthen or destroy the patient–physician relationship [1–7]. This is particularly true in the oncology setting, where patients and families often receive difficult or distressing news. Despite the importance of this skill in practice, formal education for medical students to communicate difficult news has been limited [8–11]. In many learning settings, the only instruction a student may receive is through direct observation of role models (attendings) while in training. Unfortunately, these experiences may not provide enough learning opportunity for students especially if they have had negative role models [8, 9].

Correspondence to: John V. Kiluk, John.Kiluk@moffitt.org.

Conflict of interest The authors declare that they have no conflict of interest.

A current trend in medical schools has been to attempt to address this issue with providing formal education in how to communicate bad or difficult news. Various techniques exist as far as educating students in this matter such as: simulated patients, role playing, didactic sessions, and assigned reading [8, 12, 13]. Some of the difficulty in providing this education comes from the fact that unlike teaching physical examination where there is a generally accepted manner to perform an exam, there are few universal guidelines for communication [14, 15]. Furthermore, in the oncology setting, there is great need to understand what patients already know about their medical condition and how much they would like to know. CDN can be done in many different styles with similar success, depending on both the physician and patient as well as the type of information to be communicated [16].

At the University of South Florida, College of Medicine, medical students are required to do a 2- to 3-h session involving only three to five students, which focused on how to communicate difficult medical news. This session involves students conveying news to a standardized patient (SP) on topics such as: a new diagnosis of cancer, recurrence of disease, or progression of metastatic disease. SPs are paid \$20/h and are trained to reenact a natural response to hearing bad news. Many SPs are cancer survivors and thus have a personal connection to the news in addition to their training. Prior to the session, the lead instructor has reviewed with each SP the nature of the news they are about to hear and provided details on the disease or condition to be discussed. Prior to the exercise, students received selected reading assignments on communication skills using the six steps of the SPIKES protocol: (1) setting up the interview; (2) assessing the patient's perception; (3) obtaining patient's invitation; (4) giving knowledge and information to the patient; (5) addressing patient's emotions with empathic response; and (6) strategy and summary [17]. Sessions take place in a fully equipped learning lab where mock exam rooms have bi-directional cameras that are activated when the medical student enters the room. After all, students have conducted their mock communication of the bad news to the SP, all students, SPs, and the instructors gather to view each videotape and receive feedback from the instructor, as well as the SP and fellow students.

While videotaping has been used for CDN at other institutions, there are no published papers on the process of reviewing the videotaped sessions in a small group setting. Some studies have had students watch student-SP sessions on closed circuit television but the student performing the interaction did not have the chance to review his or her own performance on video [8, 13, 18]. Other studies have involved video review of individual students and SPs but excluded other students from the discussion so they were not able to witness alternative methods or technique [8, 19]. The purpose of this study was to evaluate student perceptions of the method used in teaching how to break bad news.

Methods

Under Institutional Review Board (IRB) approval, fourth-year medical students during their Interdisciplinary Oncology Clerkship at the University of South Florida, College of Medicine were evaluated during the 2009–2010 academic year. Students spent 2 to 3 h partaking in a small group session going over techniques of CDN.

After completing an initial questionnaire on their medical school experience and comfort in breaking bad news, students are videotaped during a 15-min encounter with a SP. Although there are common threads to each scenario (initial reaction of patient, non-verbal communication, future availability of physician to patient), different encounters focus on different aspects of difficult news. Table 1 reviews each scenario. SPs are asked to focus on the emotional aspects of the scenario rather than asking questions specific to chemotherapy/treatment regimen or surgical technique.

Following the encounter, students gather in groups of three to five to review the videotaped interactions with the SPs and a physician specialized in cancer care (JK, SD). Each video is reviewed in this small group setting with attention brought to pointing out both good and bad techniques and suggesting alternative approaches to varied situations. An important aspect of the exercise is the involvement of the SP that can answer questions of patient perception of the student. Furthermore, all students had opportunities to comment on other interactions or ask questions regarding technique or style.

At the completion of the exercise, each student filled out a follow-up questionnaire about the small group session. One hundred and twelve students completed both the pre- and post-session questionnaire with no students refusing to participate in this study. The questionnaires were de-identified to protect the students.

Results

The clinical experience of medical students during the Interdisciplinary Oncology Clerkship with CDN varied significantly prior to the CDN teaching session. While a great percentage of students (95.5%) had previously witnessed at least one occasion of sharing bad news during their medical school education, only half the students (50.7%) had personal experience with delivering this type of information to a patient or family themselves. Prior to the teaching session, 63.4% of students felt “extremely comfortable/somewhat comfortable” in performing these duties with 66.9% having knowledge about the best techniques of discussing these situations.

Following the small group interaction, students overwhelmingly “agreed/strongly agreed” (98.3%) that the exercise was helpful and that the SPs were “very realistic/somewhat realistic” (94.7%). With regard to specific features of the session, students “agreed/strongly agreed” that “watching yourself on video” (96.4%), “watching other students on video” (98.2%), and “discussing the experience” (97.4%) were helpful aspects of the session. When asked for the most beneficial part of the entire session, 57.2% of students agreed the discussion itself was the most advantageous feature. Alternatively, other students appreciated watching the encounter on video (22.5%), the actual patient encounter (18.8%), or watching other students on video (5.4%).

Following the completion of the CDN session, students “agreed/strongly agreed” that their knowledge of best practices had increased (97.3%) with 81.2% of students “agreeing/strongly agreeing” that more sessions would be helpful. There were significant improvements in the percentage of students feeling “extremely comfortable/somewhat

comfortable” in delivering bad news (63.4% to 93.7%) as well as increased knowledge about the best techniques for discussing these situations (66.9% to 94.6%).

Discussion

As we proceed into a medical age of subspecialties and technology, we must not forget the importance of the “art” of medicine. Simple acts such as developing a relationship with a patient and their family can be forgotten between time limited visits and voicemail messages. Part of our job as medical educators is to develop the skills of young physicians to quickly overcome the obstacles of a modern practice and provide service to patients in an inclusive, efficient, and sensitive manner.

When it comes to relaying difficult news to a patient, most students learn different communication techniques through direct observation of mentors. However, senior clinicians rarely engage in role play to train medical students in developing appropriate communication skills to CDN [20]. Medical schools have begun to embrace principles of experiential learning and are introducing communication skills training to the curriculum of their students at an early stage as students are taught an important skill at the time when they are most receptive to knowledge [20]. Obviously, these interactions may produce both positive and negative approaches to developing doctor–patient relationships [8, 9]. It was with this understanding that this teaching exercise was developed so as to overcome the lack of formal education on this unique communication skill. When evaluating different techniques of communication education, it is clear that there are many different styles of learning among the students as well as different ways of “successfully” providing bad news to a patient. For these reasons, the learning session was designed to maximize the experience of the student, accounting for both varied personal learning styles and multiple ways to achieve success.

Moreover, the benefits of good communication skills are evident in the clinical setting, as patients who rate highly their doctor’s communication style have increased cancer related self-efficacy and reduced emotional distress [21]. Furthermore, patient satisfaction and the quality of communication among patients and physicians influence compliance while reducing the risk of a malpractice claim and decrease accounts of patient distress by the insensitivity of doctors while delivery of bad news [20].

Medical student’s personal learning styles were addressed by instituting a variety of platforms in which to gain experience from the exercise. For example, in addition to the one-on-one interaction with the SP, students were able to view themselves on video and notice verbal and non-verbal behaviors that may be misperceived by a patient. Emphasis was placed equally on the development of appropriate non-verbal communication skills such as establishing eye contact and reduced fidgeting with the chart. Discrete verbal skills such as providing a clear but sensitive delivery of the news were stressed (“The biopsy did not come back as we had hoped...it came back as cancer...”). Furthermore, by observing other students doing the same exercise, students are exposed to different approaches while talking to a patient that could be incorporated into their own future practices. Observing other student interactions also allowed for increased exposure to diverse potential responses by a

patient to the bad news (anger, denial, shock, tears, etc.). Finally, by having a discussion with a clinical faculty member, students learned alternative approaches that could make an acceptable encounter into an outstanding one.

The post-session survey revealed a wide variation of responses to the question about the most beneficial aspect of the interaction. While the majority students appreciated the discussion the most (57.2%), other students learned the most from reviewing the video (22.5%), the patient encounter itself (18.8%), or watching other student interactions (5.4%). Other studies have examined the value of videotape for teaching medical students how to take a personal health history or conduct a physical examination [15, 22, 23]. These studies also concluded that videotape was superior to instructor comments alone and that a combination of videotape and assessor comments was perceived by students as highly beneficial. The majority of studies that examine the use of SP and video have not included the component of peer and evaluator debriefing [1]. While the majority of studies examining the learned communication process for medical students in the context of CDN agree that any form of training is beneficial and superior to learning on the job [24, 25], there is much to be gained from a formal course that combines self-reflection, peer review, and preceptor advice.

Conclusion

In summary, our goal of educating medical students about the different communication techniques for CDN is well accomplished by this unique course. As demonstrated by pre- and post-encounter surveys, students had improved comfort with addressing difficult topics with patients. The variation of student responses as to which parts of the training they found most beneficial potentially points to different learning styles of students. Thus, this approach has the added benefit of appealing to students with diverse learning styles as well as improving self-perceived skills. Although these encounters cannot replace actual patient interactions, this exercise provides a safe learning environment for the student. As a result, these students will have a solid background from which to begin the applied work of developing good communication skills in the oncology setting.

Acknowledgments

F. Alejandro Montiel-Ishino

References

1. Garg A, Buckman R, Kason Y. Teaching medical students how to break bad news. *Can Med Assoc J.* 1997; 156(8):1159–1164. [PubMed: 9141988]
2. Michaels E. Deliver bad news tactfully. *Can Med Assoc J.* 1983; 129(12):1307–1308. [PubMed: 6652598]
3. Atkinson JM. To tell or not to tell the diagnosis of schizophrenia. *J Med Ethics.* 1989; 15(1):21–24. [PubMed: 2926782]
4. Roberts CS, Cox CE, Reintgen DS, Baile WF, Gibertini M. Influence of physician communication on newly diagnosed breast patients' psychologic adjustment and decision-making. *Cancer.* 1994; 74 (1 Suppl):336–341. [PubMed: 8004605]

5. McLauchlan CA. ABC of major trauma. Handling distressed relatives and breaking bad news. *BMJ*. 1990; 301(6761):1145–1149. [PubMed: 2252928]
6. Slavin LA, O'Malley JE, Koocher GP, Foster DJ. Communication of the cancer diagnosis to pediatric patients: impact on long-term adjustment. *Am J Psychiatry*. 1982; 139(2):179–183. [PubMed: 7055287]
7. Professional development. Breaking bad news: the role of the nurse (continuing education credit). *Nurs Times*. 1994; 90(11):5–8.
8. Rosenbaum ME, Ferguson KJ, Lobas JG. Teaching medical students and residents skills for delivering bad news: a review of strategies. *Acad Med*. 2004; 79(2):107–117. [PubMed: 14744709]
9. Fallowfield LJ. Things to consider when teaching doctors how to deliver good, bad and sad news. *Med Teach*. 1996; 18(1):27–30.
10. Baile WF, Kudelka AP, Beale EA, Globler GA, Myers EG, Greisinger AJ, et al. Communication skills training in oncology. Description and preliminary outcomes of workshops on breaking bad news and managing patient reactions to illness. *Cancer*. 1999; 86(5):887–897. [PubMed: 10463990]
11. Vetto JT, Elder NC, Toffler WL, Fields SA. Teaching medical students to give bad news: does formal instruction help? *J Cancer Educ*. 1999; 14(1):13–17. [PubMed: 10328318]
12. Gaffan J, Dacre J, Jones A. Educating undergraduate medical students about oncology: a literature review. *J Clin Oncol*. 2006; 24 (12):1932–1939. [PubMed: 16622269]
13. Bowyer MW, Hanson JL, Pimentel EA, Flanagan AK, Rawn LM, Rizzo AG, et al. Teaching breaking bad news using mixed reality simulation. *J Surg Res*. 2010; 159(1):462–467. [PubMed: 19665731]
14. Ptacek JT, Eberhardt TL. Breaking bad news. A review of the literature. *JAMA*. 1996; 276(6):496–502. [PubMed: 8691562]
15. Nilsen S, Baerheim A. Feedback on video recorded consultations in medical teaching: why students loathe and love it—a focus-group based qualitative study. *BMC Med Educ*. 2005; 5:28. [PubMed: 16029509]
16. Eggly S, Penner L, Albrecht TL, Cline RJ, Foster T, Naughton M, et al. Discussing bad news in the outpatient oncology clinic: rethinking current communication guidelines. *J Clin Oncol*. 2006; 24 (4):716–719. [PubMed: 16446346]
17. Baile WF, Buckman R, Lenzi R, Globler G, Beale EA, Kudelka AP. SPIKES—a six-step protocol for delivering bad news: application to the patient with cancer. *Oncologist*. 2000; 5(4):302–311. [PubMed: 10964998]
18. Rosenbaum ME, Kreiter C. Teaching delivery of bad news using experiential sessions with standardized patients. *Teach Learn Med*. 2002; 14(3):144–149. [PubMed: 12189633]
19. Goldschmidt RH, Hess PA. Telling patients the diagnosis is cancer: a teaching module. *Fam Med*. 1987; 19(4):302–304. [PubMed: 3622979]
20. Arnold SJ, Koczwara B. Breaking bad news: learning through experience. *J Clin Oncol*. 2006; 24(31):5098–5100. [PubMed: 17075128]
21. Zachariae R, Pedersen CG, Jensen AB, et al. Association of perceived physician communication style with patient satisfaction, cancer-related self-efficacy, and perceived control over the disease. *Br J Cancer*. 2003; 88:658–665. [PubMed: 12618870]
22. Paul S, Dawson KP, Lanphear JH, Cheema MY. Video recording feedback: a feasible and effective approach to teaching history-taking and physical examination skills in undergraduate paediatric medicine. *Med Educ*. 1998; 32(3):332–336. [PubMed: 9743791]
23. Ozcakar N, Mevsim V, Guldal D, Gunvar T, Yildirim E, Sisli Z, et al. Is the use of videotape recording superior to verbal feedback alone in the teaching of clinical skills? *BMC Public Health*. 2009; 9:474. [PubMed: 20021688]
24. Fallowfield L, Jenkins V. Communicating sad, bad, and difficult news in medicine. *Lancet*. 2004; 363(9405):312–319. [PubMed: 14751707]
25. Colletti L, Gruppen L, Barclay M, Stern D. Teaching students to break bad news. *Am J Surg*. 2001; 182(1):20–23. [PubMed: 11532409]

Table 1

Scenarios discussed during CDN sessions

Scenario number	Scenario	Themes to cover
1	Initial diagnosis of breast cancer	Initial shock/disbelief Importance of providing hope without promising unrealistic or unknown expectations in the face of unknown stage of disease Future availability to answer questions
2	Recurrent colon cancer with unresectable metastatic disease 3 years after initial therapy	Inoperable/incurable disease Estimated survival rate
3	Progressive metastatic melanoma without any further available treatment options	End of life issues Quality of life/palliation Hospice Family needs
4	Surgical counseling on need of colostomy for treatment of anal squamous cell carcinoma after failed chemoradiation in a patient who wishes to avoid a colostomy	Patient autonomy Importance of determining specific patient concerns
5	Treatment of early stage ovarian cancer (total hysterectomy and bilateral salpingo-oophorectomy) in newly married patient that wishes to have children	Importance of informing patient of risks of refusing recommended treatment
6	Treatment of prostate cancer that will likely cause impotence	Discussion of alternate treatment options, including risks and benefits Support groups