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Breaking Bad News: A Small-Group Learning Module and Simulated Patient Case for Preclerkship Students

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Abstract

Introduction: Breaking bad news is a difficult skill that can elicit significant distress among learners. As such, it is important for learners to practice this skill in a controlled environment, which affords time to address any distress that arises and the opportunity to receive supportive feedback on performance. This breaking bad news module was designed for preclerkship students with previous training in basic communication skills and served as capstone to the preclerkship portion of the communication skills curriculum. **Methods:** The small-group session was delivered to groups of 10-12 students and facilitated by a faculty member with expertise in communication skills. The small-group session included approximately 60 minutes of didactics and discussion, followed by a 30-minute faculty demonstration with simulated patients (SPs). Learners then had 30 minutes to practice with the SPs and received constructive feedback from the SPs and the faculty facilitator. Approximately 1 week following the small-group module, learners participated in an individual encounter with an SP and were assessed on physical examination skills and communication skills. Learners received detailed evaluations and feedback on breaking bad news skills from the SPs. Finally, learners had individual feedback meetings with their faculty facilitator, who reviewed the videotaped encounters, focusing on performance and experience of breaking bad news to the SP. **Results:** In the 2015-2016 academic year, 217 medical students participated in this module. Learners demonstrated proficiency in the physical exam skills with 90% of learners asking about 5/8 components of the presenting complaint and 85% performing 5/8 physical exam maneuvers correctly. Similarly learners demonstrated expected levels of competence in interpersonal and communication skills. **Discussion:** This learning exercise provided training in a critical communication skill but also supplied a framework for assessing and responding to personal and patient distress.

Keywords

Communication Skills, Breaking Bad News

Educational Objectives

By the end of this session, learners will be able to:

1. Identify common barriers to effectively delivering bad news to patients.
2. Use advanced communication skills to address distress while breaking bad news.
3. Utilize an empirically supported approach to deliver bad news.
4. Address personal distress experienced when delivering bad news.

Introduction

Sharing upsetting prognostic and diagnostic information is an essential but unsettling part of medical practice. Historically, medical schools have deferred addressing this topic to the clinical years or even to graduate medical education, relying on happenstance to provide appropriate mentors and clinical opportunities. However, with the increased acknowledgment that skills in breaking bad news in a consistent, compassionate manner do not emerge spontaneously, there has been more attention paid to fostering these skills and doing so relatively early in medical training. Thus, the current module was developed to provide both a cognitive framework and a simulation experience in breaking bad news in the context of an ongoing communication skills program. This activity is intentionally targeted toward

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Appendices

- A. Small-Group Facilitator Guide.docx
- B. Script for Simulated Patient McIntyre.docx
- C. Door Charts for Simulated Patient McIntyre.docx
- D. Simulated Patient Training Guide.docx
- E. Script for Simulated Patient Allen.docx
- F. Door Charts for Simulated Patient Allen.docx
- G. History-Taking Checklist for Simulated Patient Allen.docx
- H. Physical Exam Checklist for Simulated Patient Allen.docx
- I. Interpersonal and Communication Skills Rating Form.docx
- J. Event Scheduling Template.xlsx
- K. Event Protocol and Checklists.docx
- L. Documentation Template for Simulated Patient Allen.docx
- M. Self-Assessment Template.docx
- N. Interpersonal and Communication Skills Rating Form Training Guide.pdf

All appendices are peer reviewed as integral parts of the Original Publication.

junior learners (e.g., preclinical students) to provide them with a controlled experience in which to develop a framework to apply these skills in less-controlled clinical environments.

This module was designed to offer initial training, a simulated experience, and individual feedback about providing bad news to patients. It also is appropriate for standard setting and retraining for clinicians reentering practice or transitioning to a new clinical setting. The module and script were developed for medical students at the end of their second year (i.e., just prior to beginning their clerkships) but would also be appropriate for students in nursing and physician's assistant programs at a similar level of training. Ideally, learners encountering this module will have had significant exposure to both formal instruction and simulation experiences in basic communication skills, particularly, active listening and empathic reflection. Some experience of direct patient care in ambulatory settings is helpful but not essential.

The cognitive framework for this module is based on the SPIKES protocol, which provides a six-stage model for each breaking bad news encounter.¹ This protocol was chosen because it is empirically validated and sufficiently well established as to have a degree of acceptance in a range of clinical settings. Moreover, our prior efforts in teaching these skills had been overly reliant on the expertise and personal style of individual instructors; thus, a standard protocol was adopted. This framework and, we believe, this module also help prepare young providers to meet the heightened expectations and self-advocacy of increasingly informed patients. This is particularly important when the difficult news being shared involves end-of-life care and decision making, as patient advocacy around these matters is particularly well organized.

The small-group activities of the module are focused on cognitively, emotionally, and logistically preparing students for the simulation exercise, which culminates in disclosing findings of colon cancer. In addition to introducing the SPIKES protocol, the small groups also utilize role-playing and collaborative problem solving to explore the challenges and opportunities inherent in delivering bad news. While these educational techniques are a long-established part of our broader communication curriculum, they also have been successfully employed by others specifically for shaping skills used in breaking bad news.^{2,3}

Methods

Target Audience

This module was designed for second-year medical students who have significant training in communication skills and previous experience with standardized patient (SP) encounters. In our current curriculum, this module was the final module of a 2-year-long Physicianship course that included eight formative encounters. Each encounter was preceded by a small-group session focused on specific communication skills (e.g., active listening, demonstrating empathy, addressing sensitive topics, negotiating a treatment plan, etc.). Following each small-group session, students participated in an individual SP encounter, completed a self-assessment, and received individual feedback from the SP and a faculty facilitator. This module served as the eighth and final formative encounter.

Pregroup Materials

In order to maximize engagement in the small-group module, learners were provided with optional background reading materials posted on the medical college online learning site. For our delivery of this module, learners were provided with an article describing the SPIKES model for breaking bad news,¹ as well as an article on the patient perspective on receiving bad news.⁴ However, completion of this background reading is not required for delivery of the module, and facilitators may omit the reading or choose alternative background reading.

Small-Group Module

Training process: At the start of the course, faculty facilitators were provided with a comprehensive handbook that included overall communication curriculum objectives and training materials for the interpersonal and communication skills rating form. Facilitators met as a group with the faculty coordinator

to watch and score sample videos to promote interrater reliability. Throughout the course, the faculty coordinator reviewed a random set of faculty evaluations to check for reliability and correct any potential rater drift. Faculty also received training in providing feedback to students, with an emphasis on (1) providing specific behavioral examples of effective and less effective communication skills, (2) assessing and addressing students' insight into patients' responses to ineffective communication skills, and (3) addressing and providing support for any student distress upon receiving feedback. In our program, all faculty facilitators are clinical psychologists and, as such, are encouraged to utilize their own clinical expertise to address significant student distress.

Prior to this specific breaking bad news module, the faculty coordinator also sent materials specific to the module, including (1) the small-group facilitator guide (Appendix A), (2) the script for simulated patient McIntyre presenting with irregular periods (Appendix B), and (3) the door charts for simulated patient McIntyre presenting with irregular periods (Appendix C).

SP training process: At our institution, all SP trainers are also active SPs. We planned for unexpected absences by selecting an SP trainer who matched the demographics of the case of a woman with irregular periods. Six SPs were recruited to portray the case. SPs were provided with the case approximately 1 month prior to the event and were compensated for 1 hour of home study. This allowed the SPs time to familiarize themselves with the case and prepare any questions prior to the on-site training session. All six SPs were present at the 2-hour on-site training session (see Appendix D for the SP training guide). Most SPs had participated in previous cases and attended previous training sessions at our institution. After reviewing the case and resolving any questions, each SP was certified on her knowledge of the case by participating in a mock encounter. SPs also took turns portraying the student interviewer, to encourage empathy and promote student-focused feedback. Each mock encounter included a mock interview and subsequent group debriefing/feedback. The SP received guidance and feedback from the SP trainer on both the case content/portrayal and the group debriefing. On the day of the session, before joining the small groups, SPs reviewed case details and practiced debriefing/feedback skills with the SP trainer, who was on-site serving as the event manager.

Space requirements: The space required to deliver this module varies based on class size. For our curriculum, the module was delivered over 4 days to all second-year students in groups of 10-12 students each with a faculty facilitator. With our class size of approximately 130 students, this required three simultaneous groups on each of 4 days. Each day, the module required three classrooms each with sufficient space for 12 students, one faculty member, and two SPs. For the second portion of the module, the small group was divided in half, and each half was paired with an SP; thus, classrooms needed to be large enough for the group to be comfortably divided, with enough distance so that each half did not distract the other.

Time requirements: The small-group session was designed to last 2 hours on the following schedule:

- 1:00-2:00 pm: didactics and discussion in full group of 10-12 students.
- 2:00-2:20 pm: faculty demonstration of encounter with SP.
- 2:20-2:30 pm: debrief of faculty demonstration with full group of 10-12 students.
- 2:30-3:00 pm: small-group practice with SPs (group is divided in half, and each half is paired with an SP).

Personnel requirements: As with space requirements, personnel requirements vary based on the class size and the number of groups. For our class, each day that the small groups were delivered required three faculty facilitators (one per group), six SPs (two per group), one faculty coordinator, and one SP trainer/event manager.

Costs: Total costs come to approximately \$1,000.

- One hour of home study for each of six SPs at \$24/hour = \$144.
- Two hours of on-site training for each of six SPs at \$24/hour = \$288.
- Two hours of on-site work for one case trainer at \$24/hour = \$48.
- Three hours of event-day work for each of six SPs at \$24/hour = \$432.
- Three hours of event-day work for one event manager at \$24/hour = \$72.

Documents needed: For the small-group session, the following documents were needed:

1. Small-group facilitator guide (Appendix A).
2. Optional small-group prereading material.^{1,4}
3. Script for simulated patient McIntyre (Appendix B).
4. Door charts for simulated patient McIntyre (Appendix C).

Individual SP Encounter

Training process: Prior to assignment to a particular case, all SPs underwent training in use of the interpersonal and communication skills rating form (see Appendix I). SPs were provided with the rating form training guide (see Appendix N), which provides sample behaviors for each level of performance on each domain of the scale. Particular attention was paid to ratings on the low end of scale (i.e., rating of 1) to address any SP concerns about providing low ratings. SPs were assured that ratings of these events were used for formative assessment and that assignment of a low rating, when applicable, would be beneficial for student development and growth. Sixteen SPs were then selected to portray the case of simulated patient Allen complaining of bloody stool (Appendices E & F). As with the small-group sessions, the SP trainer selected was demographically appropriate to portray the case. The case was sent to SPs approximately 1 month before the event, and they were compensated for 1 hour of home study. All SPs participated in 4 hours of in-person training, generally broken up into two 2-hour sessions (see Appendix D for the training guide). At the first session, SPs reviewed the case and clarified any questions, participated in demonstrations of applicable physical exam maneuvers, discussed specificity of checklist items and qualifying answers, and received an overview of our institution's written feedback guidelines (see Appendices G, H, & I for checklists). In the second training session, SPs participated in a mock interview/physical exam to certify their knowledge of the case. SP rater calibration was performed for the history, physical, and communication skills checklists. All participants completed all checklists after each mock encounter, and the results were immediately compared and discussed to reach standardization. Ten training sessions were required in order to accommodate all SPs, meeting in groups no larger than four to allow for appropriate individual attention.

Space requirements: For our curriculum, this SP encounter occurred for all learners in a single day. For our class size of approximately 130 learners, this required access to 16 exam (or mock-exam) rooms for the encounters, a large room with tables and power outlets for students to document their encounters, a space for conducting orientation, changing space for SPs, a break room for SPs, and a space for data processing. At our institution, we conducted these encounters in an actual clinical space during a time when patient visits were not being held. This allowed access to (1) 16 exam rooms equipped with exam tables and computers for the encounters, (2) a conference room for learner documentation, (3) a waiting room for orientation, (4) bathrooms for SPs to change, (5) a small conference room for an SP break room, and (6) a resident station with computers for data processing.

Time requirements: Each individual SP encounter was conducted in two parts, labeled Parts A and B. For Part A, the learner had 10 minutes to collect a history of the patient's presenting complaint (i.e., bloody stool) and conduct a focused physical examination. The learner then had 10 minutes to document the history of present illness and physical exam from Part A. The learner then received additional test results

and instructions (i.e., “Inform the patient that colonoscopy results indicate advanced malignancy”). For Part B, the learner had 10 minutes to break this news to the patient and address patient distress. There was no documentation following Part B. Thus, each SP encounter took approximately 35 minutes, including 5 minutes of time for learners to move between stations. Learners completed encounters in groups of 16, and each group of encounters was preceded by a 10-minute group orientation.

All students completed their SP encounters on a single day on the following schedule:

- 10:00 am: event staff arrival time (call-time).
- 10:15 am: SP and videographer arrival time (call-time).
- 10:50 am: Group 1 orientation followed by SP encounters.
- 11:35 am: Group 2 orientation followed by SP encounters.
- 12:20 pm: Group 3 orientation followed by SP encounters.
- 1:05 pm: Group 4 orientation followed by SP encounters.
- 2:00-2:20 pm: break for event staff and SPs.
- 2:20 pm: Group 5 orientation followed by SP encounters.
- 3:05 pm: Group 6 orientation followed by SP encounters.
- 3:50 pm: Group 7 orientation followed by SP encounters.
- 4:35 pm: Group 8 orientation followed by SP encounters.
- 5:20-6:30 pm: event cleanup.

Event setup (e.g., camera setup) occurred on the previous afternoon and took approximately 2 hours. Templates for event scheduling and protocols are included in Appendices J and K.

Completion of SP checklists: Following Part A of the encounter, SPs completed a history-taking checklist (Appendix G) and a physical examination checklist (Appendix H). These checklists were completed on computers within the exam rooms using online survey collection data. SPs were provided with web links (unique to each student) that directed them to online versions of the rating forms. SPs had approximately 10 minutes to complete these checklists while learners were completing their documentation in a separate room. Following Part B of the encounter, SPs completed the interpersonal and communication skills rating form (Appendix I). As with Part A, the rating form was completed on computers within the exam rooms using online survey collection data. SPs had approximately 10 minutes to complete this form while the next group of learners was attending group orientation. Throughout the event, survey data were reviewed by the event manager to check for missing/incorrect data.

Completion of learner documentation: Following Part A of the encounter, learners documented it using personal laptops or tablets in the designated space (i.e., large conference room with tables and outlets). Learners had 10 minutes to complete this documentation. A template for documentation is provided in Appendix L. When learners completed their documentation, they returned to the exam room and received additional instructions via the door chart for Part B.

Personnel requirements: As with space requirements, personnel requirements vary based on the class size. For our class, the event day for the SP encounters required 16 SPs, eight videographers, two video processors, one proctor for documentation, and one SP trainer/event manager.

Equipment requirements: As with space and personnel requirements, equipment requirements vary based on the resources available for simulations at an institution. As these encounters were conducted in actual clinic rooms, rather than simulation rooms, additional video-recording equipment was required. For our event, the following equipment was needed: (1) two video cameras per exam room for a total of 32 cameras, (2) one computer per exam room for SPs to complete learner evaluations for a total of 16 exam room computers, (3) one gown and drape per SP for a total of 16 gowns and 16 drapes, (4) clipboard, pen, and scratch paper per exam room for a total of 16 each, (5) one stopwatch per videographer for a total of

eight stopwatches, (6) two computers for video processing, and (7) one computer for SP evaluation review by event manager.

Costs: Total costs came to approximately \$6,500.

- Four hours of case-specific training for each of 16 SPs at \$24/hour = \$1,536.
- Four hours of on-site work for one case trainer at \$24/hour = \$96.
- Eight hours of event-day work for each of 16 SPs at \$24/hour = \$3,072.
- Eight hours of event-day work for eight videographers/proctors at \$24/hour = \$1,536.
- Eight hours of event-day work for one event manager at \$24/hour = \$192.

Documents needed: For the SP encounters, the following documents were needed:

1. Event schedule template (Appendix J).
2. Event protocol and checklist (Appendix K).
3. Door charts for simulated patient Allen (Appendix F).
4. History-taking checklist (Appendix G).
5. Physical examination checklist (Appendix H).
6. Interpersonal and communication skills rating form (Appendix I).
7. Documentation template (Appendix L).

Self-Assessment

Following the individual SP encounter, learners had approximately 1 week to review their videotaped encounter (which was posted online) and complete a self-assessment. Learners were provided with a template to complete this assessment (Appendix M). Learners emailed this self-assessment to their faculty facilitator at least 24 hours before their scheduled feedback session so that faculty had time to review and incorporate student comments into the feedback session.

Individual Feedback Sessions

Individual feedback sessions lasted 20-30 minutes each and were scheduled individually between the learners and their assigned faculty facilitator. Total time for feedback sessions (assuming a group size of 10-12 students) was 5-6 hours per faculty member. Faculty were allocated an additional 10-12 hours to review the videotaped encounters, review student self-assessments, review checklists and rating forms completed by SPs, and complete evaluations of communication skills using a parallel version of the interpersonal and communication skills rating form (a copy is provided in Appendix I).

Results

This module was delivered to 127 second-year medical students in academic year (AY) 2015-2016. Twelve faculty facilitators (master's or doctoral level psychologists) conducted the small-group sessions, and 16 SPs participated in the individual SP encounters. All students completed a two-part encounter, where each part of the encounter had specific objectives and educational goals. Part A focused on history-taking and physical examination skills, and students were expected to engage in these activities using active listening skills and behaviors to display empathy to the patient as they collected information about sensitive and distressing symptoms. Part B focused on the delivery of bad news (i.e., recurrence of cancer with a poor prognosis), and students were expected to use specific behaviors (e.g., aspects of the SPIKES model) as practiced in the small-group session to deliver this news.

Learner Performance

For Part A, learners demonstrated proficiency in collecting facts about the presenting complaint, with more than 90% of learners asking about (1) onset of symptoms, (2) quality of symptoms, (3) time course of symptoms, (4) associated symptoms, and (5) social history, namely, substance use. Learners were less consistent in asking psychosocial aspects such as the patient's perspective on the symptoms (83% of learners) and the impact of the symptoms (77% of learners). Only 29% of learners asked about relevant

family medical history (i.e., history of colon cancer). With respect to the physical examination, learners demonstrated proficiency in five maneuvers, with 85% or more of learners successfully (1) washing their hands, (2) using appropriate draping, (3) verbalizing inspection of abdomen, (4) auscultating abdomen, (5) and palpating abdomen. Students performed poorly on three maneuvers: (1) checking for rebound tenderness, (2) percussing abdomen, and (3) palpating liver edge.

For Part B, learners demonstrated expected levels of competence in interpersonal and communication skills. Learners performed higher in basic communication skills (e.g., beginning the encounter: $M = 3.1$, $SD = 0.7$; gathering information: $M = 3.2$, $SD = 0.6$; and supporting emotions: $M = 3.4$, $SD = 0.8$), which was expected as they had practiced these skills in seven prior SP encounters. Learners had lower performance in more advanced communication skills (e.g., providing information: $M = 2.7$, $SD = 0.9$; making decisions: $M = 2.3$, $SD = 0.9$), which was also expected given the nature of this encounter. Learners demonstrated surprisingly low performance in ending the encounter ($M = 1.9$, $SD = 1.1$), which was attributed to unease in determining the next steps for the patient given the difficult diagnosis. Of note, scores on each of the communication domains spanned the full range of performance ratings (range = 1-5).

Comments From Small-Group Facilitators

Faculty facilitators reported that this module addressed an important topic and was well received by students. One facilitator remarked, “Extremely important topic. While the idea of breaking bad news may have intimidated the students at first, I think nearly every one of them told me they were really glad it was addressed.” Suggestions from the faculty for improvement included the following:

- “Although the module goal is not to focus on the medical background, students may need a bit more information on the rationale for requesting the tests they tell the patient they should do (so they can answer patient questions).”
- “Door chart may need to be more specific about how much they can go into providing info on treatment options, as students felt stuck by just ‘giving the news’ then not being able to give them further information, even when the patient requested it.”
- “Student readiness exercise may have been more meaningful by asking students to do something more than read an article such [as] ‘Journal about a time you were given bad news and how the process of getting the news made you feel.’”
- “May have been helpful to provide more background on the definition and types of palliative care.”
- “[This event] worked very well as a sort of capstone interview where students really needed to put all their skills together to be effective here. The students who had struggled with individual pieces (e.g., appropriate empathy, open-ended questions, avoidance of jargon, etc.) REALLY struggled with putting it all together for this one, especially in the context of a great deal of difficult emotions on both sides.”

Comments From Event Manager

The event manager kept detailed notes during the event day to note any logistic issues. Overall, she concluded that the event ran very smoothly and that SPs were pleased with event space, with only minor logistical issues occurring. Suggestions for improvement from her review of the event included the following:

- “One SP called in sick and thus the event manager served as the SP for that exam room. This highlighted the need for a back-up SP in the event that more than one scheduled SP is unable to attend.”
- “Written feedback was decreasing in specificity and length after round five. This was a very long day, especially as the case was a bad news case. Perhaps we can build in more breaks or schedule a shorter day to help alleviate SP fatigue and increase rating reliability.”
- “Students were often complaining about the noise spill-over from room to room and were confused about what warning knock was for which room. Eventually, we asked our videographers to crack open the door when the encounter was over to help alleviate some of that confusion.”

- “Having students document on their own devices worked well for the most part although some were surprised they could use a Bluetooth keyboard [for their tablets], despite our reminder email. Going forward we should strongly encourage students to bring either their laptop or a Bluetooth keyboard to most effectively document their encounter.”
- “According to anecdotal SP summaries, about a third of students were not delivering the bad news as if it were a fatal diagnosis. Perhaps adding some information to the door chart (e.g., cancer state, life expectancy, etc.) would help clear up some of the ambiguity.”

Discussion

The purpose of this module was to provide preclerkship medical students with a framework and safe environment to practice breaking bad news to patients. Part of the rationale for the development of this module was in response to student desire to practice these skills. This module was first introduced into the curriculum in AY 2014 and modified to its current format in AY 2015. At the end of the module, learners were expected to (1) identify common barriers to effectively delivering bad news to patients, (2) use advanced communication skills to address distress while breaking bad news, (3) utilize an empirically supported approach (the SPIKES model) to deliver bad news, and (4) address personal distress experienced when delivering bad news. These objectives were achieved through a three-part module. First, learners participated in a small-group discussion session with a faculty facilitator that focused on identifying barriers to delivering bad news and provided instruction in the SPIKES¹ model for delivering news. Second, learners participated in an individual SP encounter during which they were to disclose a life-threatening diagnosis. Finally, learners participated in significant individualized feedback, which included feedback from SPs, self-assessment, and feedback from faculty facilitators.

Overall, this module was successful in meeting student needs and our proposed objectives. The small-group session was well organized and well received. The individual SP encounter provided realistic and appropriate levels of student distress (i.e., desired discomfort in delivering the bad news) and patient distress (i.e., desired emotional response from the patient that the student needed to address). The feedback sessions were effective in encouraging students to reflect on both their own and the patient's distress and to develop a plan for individual improvement in the skill of breaking bad news. With respect to logistics, the module was delivered smoothly, with only minor challenges that can be easily addressed in future administrations. We feel this module is a well-organized, effective module on breaking bad news with an appropriate level of content and emotional impact for second-year medical students who are preparing to enter clerkship.

In our review of the faculty and event manager comments, we identified three key limitations, with corresponding opportunities for improvement. First, some of the small-group facilitators commented that the practice opportunities during the small-group sessions did not adequately prepare learners for the individual SP encounter. Specifically, it was suggested that the practice case (i.e., a diagnosis of premature ovarian failure) did not carry the same emotional valence as the individual case (i.e., a diagnosis of colon cancer). In addition, it was suggested that students received more benefit from the faculty demonstration and debrief than from the small-group practice with the SP. Learners commented that they did not feel ready to practice with the SP and that practice in small groups was not conducive to addressing personal and patient distress. Second, during the individual SP encounters, the SPs noted that there was significant variance in the level of bad news that learners disclosed to them. Approximately one-third of students provided more promising results (e.g., did not disclose the terminal nature of the cancer diagnosis), and thus, the level of emotion experienced during the encounter was likely much lower for those learners, as compared to the learners who broke bad news of a terminal cancer diagnosis. This likely reduced the effectiveness of the encounter and limited the learners' ability to achieve the objective of addressing

personal distress experienced when delivering bad news. Finally, the event manager noted that SP comments decreased in quality as the day progressed, attributing this to fatigue on the part of the SPs as it was a long day and an emotional case.

Based on these limitations, we are planning three revisions for next year. First, we are planning to make changes to the pregroup materials and pregroup assignment. Specifically, students will be provided with an introductory article on palliative care that includes the definition, goals, and types of palliative care. Material with a focus on oncology will specifically be chosen to help students prepare for the SP encounter. For their readiness exercise, learners will be asked to read this material and then write a one- to two-page reflection on the following prompt: “Journal about a time you were given bad news and how the process of getting the news made you feel.” It is expected that this more active preparation assignment will better engage students with the material. Second, we are planning to make changes to the practice script so that the emotional valence and severity of the diagnosis are commensurate with the subsequent SP encounter script. Based on facilitator and SP comments, we may change the practice case to one of metastatic ovarian cancer (rather than premature ovarian failure) in order to provide learners with an opportunity to practice communication skills within the context of palliative care. Lastly, we plan to make changes to the scheduling of the simulation event day to prevent SP fatigue. Options include scheduling more frequent SP breaks and scheduling SPs in two separate shifts so that each SP completes a smaller number of encounters and evaluations.

The cited limitations notwithstanding, we feel this educational activity was extremely beneficial to learners, allowing them the unique opportunity to practice breaking very difficult news to patients in a safe, controlled environment and to receive meaningful feedback from both SPs and expert faculty. In particular, we feel this activity provides a novel and important opportunity for junior learners to practice these skills and receive formative feedback from patients so that these learners may develop a foundation for deepened understanding and application of these skills during clerkships and in clinical practice, where opportunities for patient feedback may be limited.

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