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Research Paper

Perspectives About Breaking Bad News Among Medical Students of Qom University of Medical Sciences

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ABSTRACT

Background and Objectives: Undoubtedly, breaking bad news is one of the most difficult duties of a doctor. Not having this skill and not paying attention to its details can result in poor patient satisfaction, psychological morbidity, and weak clinical decisions. The present study was conducted to investigate the medical students' perspectives about delivering bad news to patients.

Methods: A cross-sectional study was conducted using a questionnaire for all medical students of Qom University of Medical Sciences, Iran. A total of 269 out of 310 students responded to this survey (86.8% response rate). The questionnaire was designed and validated by ten medical ethics experts.

Results: In this study, 54.4% of students believed that delivering bad news to patients depends on the patient's compliance and condition and 55.8% of the participants believed that patients' families should be the first recipient of the bad news. In addition, 54.3% believed that physicians should deliver the bad news. A total of 78.8% of the participants believed that breaking bad news should be accompanied by empathy and hope Also, 47.6% of students said that they did not receive training about breaking bad news.

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

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Introduction

Maybe no encounter between a doctor and a patient is more stressful than the encounter in which bad news is given [1]. Delivering bad news is difficult for doctors and medical students [2]. All doctors have 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 most doctors are reportedly 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 communication with the patient, and especially the delivering bad news [5]. In addition, if bad news is delivered correctly, it can relieve the patient's pain [6]. On the other hand, miscommunication is one of the common causes for patients to complain against doctors [7]. Some patients blame the doctor in response to bad news. This false-negative attitude towards physicians who deliver bad news is understandable, as many of them do not use the correct way to deliver bad news [8].

In addition to cultural differences, many other factors also affect the physician's judgment about delivering bad news [9]. The most crucial 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 delivering bad news [11].

The first and the most critical obstacle in the way of conveying bad news is the lack of skills and training about it, which requires the beginning of training in medical schools [12].

Appropriate training on how to deliver 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 significantly reduce the health and satisfaction of patients and health care professionals [14].

Considering the importance of the research mentioned above, in this study, by studying the perspectives of students on how to deliver bad news 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 about delivering bad news to patients.

Methods

This cross-sectional study was conducted on all the medical students, in one educational University located in an urban area of Iran, in 2015. All medical students were asked to participate in the survey and the decision as to whether or not to take part in this study was completely voluntary. Of the 310 medical students, 41 of them 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 the published literature on breaking bad news. The questions were validated by ten medical ethics experts. All participants were asked to give verbal informed consent. Data were collected via questionnaires without recording any identifiable information. The University Ethics Committee Review Board approved the study protocol. SPSS v. 18.0 was used to analyze data.

Results

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. Table 1 presents the baseline characteristics of the participants.

A total of 46.8% of participants believed that the patient should be informed about her/his untreated illness; however, 7.8% disagreed with this topic and 45.4% believed that the decision on this topic depends on the patient's adaptive compliance. Table 2 presents medical students' perspectives on how to deliver bad news.

A total of 44.6% of medical students believed that bad news should be delivered to the patients along with hope; however, only 3.7% believed that it should be delivered without hope. Table 3 presents medical students' perspectives on what to deliver about bad news.

Table 1. Baseline characteristics of the study population (n=269)

Characteristics		No. (%)
Age (y)	18-20	117(43.5)
	21-25	142(52.8)
	26-30	10(3.7)
Sex	Male	94(34.9)
	Female	175(65.1)
Level of training	Basic science (the first to the fifth semester)	153(56.9)
	Introduction to clinical medicine (the sixth and the seventh semester)	28(10.4)
	Stager (the eighth to the eleventh semester)	67(24.9)
	Internship (Last three semesters)	21(7.8)
Marital status	Single	225(83.6)
	Married	43(16)
	Divorce	1(0.4)
	Widow or widower	0(00
Birthplace	A Native of the province	147(54.6)
	Other provinces	122(45.4)

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

Table 2. Medical students' perspectives on how to deliver bad news

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

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

Table 3. Medical students' perspectives on what to deliver about bad news

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

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

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

Discussion

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

Students (45.4%) believed that delivering bad news to patients depends on the patient's compliance and condition. Participants (46.8%) believed that the patients should be informed about their untreated illnesses.

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 delivering 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 delivering 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' families and 19.7% believed that patients should be the first recipient of bad news.

In Leppert's study, 28% of doctors and 32% of students believed that the first recipient of bad news should be the patient's family but the others believed the patient should be the first recipient of bad news [2].

Table 4. Medical students' perspectives concerning education about delivering bad news

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

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

This difference between the study of 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 particularly in the Islamic societies, the family has a more vital role than in western societies. The close relationships between family members in eastern societies provide greater recognition of family members, and the family may be able to provide more favorable conditions for conveying bad news to the patient.

About the first person to deliver bad news, 54.3% of participants believed that the physician and 30.9% believed that a physician or counselor should be the person to deliver bad news. Most students seem to believe that the best provider of good news is a doctor. In a study by Managheb, 65.6% of patients believed that the best person to deliver bad news is a physician [16]. In a study by Jurkovich et al. 57% of patients said that they received bad news from the doctor [12].

About the first issue to be said during the delivery 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 the behavior of the bad news' sender should be accompanied by sympathy these results reinforce the importance of the empathy component of the SPIKES protocol, which is used to deliver bad news [17].

Medical students (64.7%) stated that it is better to deliver bad news in a clinical setting. In the Illingworth study in the United States, most American doctors believe that hospitals are a more appropriate place to provide information to patients [18]. However, in a study by Managheb 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 students selected clinical training, and 30.5% selected workshop training. In a study by Kiluk JV et al. in the United States, the clinical experience of medical students about breaking bad news significantly increased after a clinical training course [19].

Interns (38.1%) said they received incomplete education about the breaking bad news and 47.6% said they received no education. These results are consistent with many similar studies conducted on different groups of health care personnel, especially in Iran [16, 20]. While studies in other countries show better statistics [21]. Due to the complexity of breaking bad news, it is essential to elaborate an accurate educational curriculum about the cultural, religious, and economic conditions of the community.

Conclusion

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

Ethical Considerations

Compliance with ethical guidelines

This study was approved by the Ethics Committee of Qom University of Medical Sciences.

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Authors' contributions

Conceptualization and Supervision: Akram Heidari and Seyed Hasan Adeli; Methodology and Data analysis: Akram Heidari and Mohammad Aghaali; Data collection: Roghieh Hosseini-rafi; Writing - original draft: Roghieh Hosseini-rafi and Mohammad Aghaali; Writing - review & editing: All authors.

Conflict of interest

The authors declared no conflict of interest.

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