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RELEVANCE OF ROLE PLAY IN SENSITIZING UNDERGRADUATE MEDICAL STUDENTS IN BREAKING BAD NEWS

[1*]Dr. Anne Wilkinson, [2]Dr. Suresh Chari, [3]Dr. Swanand Pathak

[1]Associate Professor Pathology and MEU Member, NKP Salve Institute of Medical Sciences and Research Centre., Digdoh Hills, Hingna, Nagpur, Maharashtra 440019, India.

[2]Professor Biochemistry and Director MEU, NKP Salve Institute of Medical Sciences and Research Centre., Digdoh Hills, Hingna, Nagpur, Maharashtra 440019, India.

[3]Professor and Head Pharmacology, JNMC, Sawangi, Wardha, Maharashtra, India.

***Correspondence for Author: Dr. Anne Wilkinson**

Associate Professor Pathology and MEU Member, NKP Salve Institute of Medical Sciences and Research Centre., Digdoh Hills, Hingna, Nagpur, Maharashtra 440019, India.

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ABSTRACT

OBJECTIVES: To evaluate the effectiveness of role play, to train II MBBS undergraduate medical students, in breaking bad news. **MATERIAL AND METHODS:** IEC clearance for the project was obtained. 100 Second MBBS students were enrolled for the training with their consent. A pretest was taken. A clinical case in breaking bad news using dummy patients was given to the student. They were assessed using OSCE. The same case was given to all students. This was followed by a lecture for the whole batch and role plays involving the students, in different clinical scenarios, to demonstrate the art of breaking bad news, based on SPIKES protocol. A post role play OSCE was repeated. Post test was taken. The student's written feedback was taken. **Statistical analysis-** The results were analysed using SPSS version 20 software. Chi square test and p value was applied where necessary. Paired t test was used for comparing pre and post lecture OSCE Likert scale. **RESULTS:** The results from the pretest and post test showed that there was an Absolute learning gain of 39.65%. The paired t test applied to the pre lecture / role play OSCE and post lecture / role play OSCE showed highly significant results with a t value of 17.85 and p value <0.001. **CONCLUSION:** Based on this study we could recommend that the earlier the students are exposed to different role play in situations where they have to communicate bad news, the better it gears them in getting some direction for the same when they face real life situations.

KEYWORDS: Role play, breaking bad news, medical students.

INTRODUCTION

Bad news is any news that drastically and negatively alters the patient's view of his/her future.[1] Thayre and Hadfield suggest that losses may take many forms: a loved one's death; devastating diagnosis which shatters hopes, dreams, aspirations; disability, impairment; or poor prognosis confirming or confronting the recipient's worst fears.[2] Communicating bad news is an essential skill for physicians. The clinician is faced with the task of breaking this news and is sometimes at a loss on how to do it effectively. It is a complex task as it requires verbal as well as non verbal skills. The SPIKES protocol (Setting up interview, Perception, Invitation, Knowledge, Emotions, Strategy and Summary) developed by Baile et al in 2000,[3] is a useful 6 step strategy for breaking bad news. This project was undertaken to sensitize the young undergraduate medical students in the art of breaking bad news, by using role play which incorporated the SPIKES protocol.

OBJECTIVES

To evaluate the effectiveness of role play, to train II MBBS undergraduate medical students in breaking bad news.

MATERIAL AND METHODS

IEC clearance for the project was obtained. 100 Second MBBS students were enrolled for the training with their consent. A pretest was taken. A clinical case in breaking bad news using dummy patients was given to the student. They were assessed using OSCE. The same case was given to all students.

This was followed by a lecture for the whole batch and role plays involving the students, in different clinical scenarios, to demonstrate the art of breaking bad news, based on SPIKES protocol. A post role play OSCE was repeated. Post test was taken. The student's written feedback was taken.

Statistical analysis

The results were analysed using SPSS version 20 software. Chi square test and p value was applied where necessary. Paired t test was used for comparing pre and post lecture OSCE Likert scale.

OBSERVATION AND RESULTS

Table 1. Results of Pretest and Post test

Total respondents=100 Total marks=10

Question	PRE TEST Correct	Incorrect	POST TEST Correct	Incorrect
Definition of BAD NEWS	97	3	100	0
2 examples of BAD NEWS	94	6	100	0
Full form of SPIKES	0	100	95	5
2 qualities needed to break bad news	78	22	95	5
2 difficulties faced while breaking bad news	77	23	92	8

Average Pretest score= 4.125/10

Average Post test score= 8.09/10

Absolute learning gain= 80.9% -41.25% = 39.65%

Normalized gain g = $\frac{8.09- 4.125}{10- 4.125}$ = 0.674

Relative learning gain= $\frac{8.09-4.125}{4.125}$ X 100 = 96.12%

Table 2. Pre and Post lecture / role play OSCE analysis

	PRE LECTURE / ROLE PLAY		POST LECTURE/ ROLE PLAY		X^2	p value
	Yes	No	Yes	No		
Beginning of interview- Did the student						
Introduce self?	7	93	91	9	141	<0.001
Explain his/her purpose?	20	80	98	2	126	<0.001
Middle of interview (Nonverbal Behavior) Did the student						
Sit down?	88	12	100	0	12.77	<0.001
Assume a comfortable distance from the patient?	96	4	99	1	0.82	0.17
Directly face the patient?	98	2	100	0	2.02	0.07
Lean forward appropriately?	58	42	90	10	26.61	<0.001
Avoid inappropriate nonverbal habits (crossing arms, interrupting the patient)	80	20	92	8	5.98	<0.014
Allow moments of silence?	36	64	98	2	86.93	<0.0001
Respond nonverbally (ie: smile and nod) when the patient spoke ?	70	30	98	2	29.17	<0.001
End of interview- Did the student						
Summarize the main issues?	52	48	100	0	63.16	<0.001
Conclude by verifying patients' agreement and setting a follow-up plan?	32	68	100	0	103	<0.0001

Middle of interview (Verbal Behavior).For each skill, rate the student on the following Likert scale:					
	1 Unacceptable Performance Skill not used or poorly applied	2 Marginal Acceptable in some areas Needs improvement in others	3 Proficient Consistently performs well	4 Advanced Especially Proficient Not consistently outstanding	5 Outstanding Consistently outstanding Skill effectively and regularly applied
	Pre Role play OSCE Likert average score		Post role play OSCE Likert average score		
Speak appropriately (Pace and clarity)	2.16		2.85		
Respond to patient's emotions and encouragement?	1.91		3.67		
Match vocabulary to patient's background, appropriately explained medical terms.	2.01		3.64		
Used foreshadowing or a "warning shot"?	1.69		3.37		
Explore the patient's view of the condition (what the patient suspects is wrong?)	1.71		3.57		
Used progressive disclosure?	1.59		3.7		
Periodically assess understanding?	1.53		3.56		
Check to see if the patient wants more details?	1.58		3.82		
Honestly depicts the disease?	1.8		3.9		
Educate the patient on the condition?	2.02		3.8		
Discus the impact of the disease?	1.8		3.7		
Give ranges on prognosis (rather than absolute numbers)?	1.5		3.76		
Provide hope within reason?	1.67		3.69		
Offer assistance of other services including care, social services, and consultation?	1.64		3.68		

For the Likert scale above, paired t test was applied to the pre lecture / role play OSCE and post lecture / role play OSCE and the results were highly significant as shown below

Paired Samples Statistics						Increse mean	S.E. Mean	T value	P value
		Mean	N	Std. Deviation	Std. Error Mean				
Pair 1	Pre	1.757857	14	0.2014249	0.0538331	1.86	0.104	17.85	<o.oo1
	Post	3.6221	14	0.25661	0.06858				

Table 3. Students Feedback. n=100

	Yes	No
1. I have benefited by learning a technique to break bad news to patients / relatives	93%	7%
2. The role plays demonstrated were a good way of introducing us to the technique of breaking bad news.	91%	9%
3. I was taught this technique at the right point of my career (II MBBS)	92%	8%
4. I would like to have more practice sessions using role play, to help me develop my ability in breaking bad news effectively	87%	17%
5. Suggestions	3 students wanted frequent practice with role plays to learn the technique of breaking bad news	

DISCUSSION

The saying that "Practice makes a man perfect" may not fully be applicable in the case of using role plays in training for breaking bad news to patients and relatives. However it definitely can sensitize medical personnel and health care workers of the need to develop both verbal and non verbal skills in the art of breaking bad news. This was highlighted in this project which was undertaken, as seen in the above results which were statistically significant. The student's feedback also proved that learning this art is extremely beneficial to them.

Physicians used to believe that disclosure of bad news would cause anguish, threatening to cripple the preservation of any hope for patients, justifying thus the concealment of bad news.[4]

However, since the second half of the last century, patients, physicians, and the general public started to communicate the diagnostic and prognostic aspects with a more open and clearer approach.[5]

Interactions in which bad news is discussed are admittedly distressing for doctors, patients, and their families. The way the diagnosis of serious diseases, like cancer, is communicated can have a significant impact not only on the perceptions of patients about their disease, but also on the long-term relationship with their physician.[6] The importance of the interaction in breaking bad news cannot be overlooked, and research has highlighted that the way health professionals approach this encounter can have a significant impact on the patient's adjustment and functioning.[7,8] There are many models for teaching skills for delivering bad news, and the choice depends on resources available in terms of faculty, standardized patients, and curricular time.[9]

Few empiric studies were available to guide clinicians on how to break bad news effectively. In the absence of such evidence, international experts developed consensus guidelines in 1995 to assist with this important task. These guidelines, along with others, have been synthesized into various recommended approaches that have in common 4 chronologic steps: (1) preparing to disclose information identified as bad news, (2) disclosing the news to the patient, (3) responding to the perceived patient reactions, and (4) making further plans.[10]

Sixty years ago, most physicians were able to avoid discomfort by concealing the truth from patients, justifying this with the claim that the truth would be too distressing for the patients. In his famous survey of 1961, Oken showed that 90% of surgeons in the US did not routinely discuss a cancer diagnosis with their patients, even though it was determined that patients really wanted to hear the diagnosis. Later, Novack and colleagues repeated the Oken survey and showed that the position was reversed. By the late 1970s, 90% of physicians told patients if they had cancer. Since then, this has become the norm. There are also legal and ethical obligations to tell our patients any detail about their illness, if that is their wish. Although most patients want full disclosure of their medical situation, some would rather not hear it or cannot cope with it. This option is built into the S-P-I-K-E-S protocol, where Setting (S), Perception (P), Invitation (I), Knowledge (K), Empathy (E), Strategy and summary (S), is an approach used in breaking bad news. The S-P-I-K-E-S protocol is a strategy and not a script. It highlights the most important features of a bad news interview and suggests methods of assessing the situation as it evolves and responding constructively to what happens.[11, 12]

Patients' perceptions of the way in which doctors deliver bad news alter understanding, decisions about treatment options, and later adjustment. There is a broad consensus of opinion about how patients want to hear news and what they need to hear. The need for an empathic delivery was reported in an Australian survey, in which patients with breast cancer wanted to be given the diagnosis and prognosis honestly and in simple language but not too bluntly. In UK, USA, Canada, Australia and Israel, there are there are many guidelines and recommendations as to how doctors should prepare themselves before imparting bad news, about what constitutes an optimum supportive environment, and how difficult information should be given.[13]

Based on the premise that communication skills can be taught, different educational strategies for medical students and physicians were developed. These strategies include didactic lectures, small-group discussions, practical individual or group performance with simulated patients, and teaching moments during clinical care. The training strategies are varied and often resource- and time-intensive for educators. The availability of new technologies based on the Internet can reduce cost and increase the applicability of these training programs.[14] Role play has been successfully used in teaching programs conducted for imparting the skill of breaking bad news.[15]

The task of breaking bad news which can drastically affect a patient or his relative is definitely not an easy one when faced with it in real life situations. The SPIKES protocol[3] which was originally developed for breaking bad news to Cancer patients, can be applied in other situations also. Training the medical graduate early in their career in the art of breaking bad news has been found to be a satisfying experience in various studies.[1,13,14,15] This art definitely requires a honing of communication skills, patience and time. Various other protocols like the ABCDE and BREAKS protocol[16] have been used in training, but ultimately as care givers, we have to be sensitive to our patients emotions when communicating any type of bad news.

Cultural background and educational status have also seen to affect the way patients and relatives receive bad news.[12] This reinforces the need of health care givers to learn local languages and also know the background from which the patient comes. Time is precious for all of us but we must realize that when we deliver any type of bad news it is definitely going to have a big impact on the patients future from the moment we tell them. Hence learning and establishing good protocols for this communication is invaluable.

CONCLUSION

Role play is an effective method in imparting the art of breaking bad news to the patients. Based on this study we could recommend that the earlier the students are exposed to different role play in situations where they have to communicate bad news, the better it gears them in getting some direction for the same when they face real life situations. Frequent sessions are required for this purpose, which will have to be worked out for their existing curriculum.

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