

Are We Training Our Fellows Adequately in Delivering Bad News to Patients? A Survey of Hematology/Oncology Program Directors

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Abstract

Background: Medical oncologists often must deliver bad news. The authors were interested in the extent of formal training in delivering bad news in hematology/oncology fellowships in the United States.

Methods: An e-mail survey was sent to all hematology/oncology fellowship program directors in the United States. Surveys were e-mailed to 124 program directors and responses were received either via e-mail or regular mail. Program directors were asked the adequacy, the perceived necessity, the quality of this training, and the institutional support provided. It was also intended to elicit responses about the degree of formal training fellows receive in delivering bad news. χ^2 Statistics were used to perform comparisons between items; p values of less than 0.05 were considered statistically significant.

Results: Sixty-five surveys were completed and returned (52% response rate). The majority of programs, 82%, are in urban areas and 97% of the primary teaching hospitals are considered tertiary care centers and 46% of programs carry a National Cancer Institute (NCI) designation. Median number of fellows in a training program is 6 with the range being 3 to 46. Eighty-nine percent of program directors reported that they themselves received little to no formal training in delivering bad news, but they report 37% of current fellows receive little to no formal training with 40% receiving some training and additional 23% receiving moderate to extensive training ($p < 0.001$). Sixty-three percent of program directors felt that extensive, formal training is important for skill development in delivering bad news, while an additional 34% felt that some training is useful. Only 3% of respondents did not believe any training is needed. Seventy-six percent of program directors want improvements in how their fellows are trained, but 43% reported little to no institutional support for training ($p < 0.001$).

Conclusions: Of the program directors who responded to our survey, a large majority did not have formal training in delivering bad news. Despite this lack of training, most program directors felt that training was useful for skill development in delivering bad news. The majority of today's fellows do receive training in delivering bad news. However, there was still a significant percentage of program directors who reported little or no formal training for fellows. Most program directors would like to see improvements in how fellows are trained. Specific institutional support for training fellows in delivering bad news remains lacking.

Introduction

GIVING BAD NEWS is not easy, and to do it properly requires good communication skills. The benefits of good communication skills and the art of delivering bad news have been discussed in many publications. One important study looked at patient preferences for receiving news about their cancer. Patients were asked to rate physician skills on a scale of 1 to 5 ranging from "not at all important" to "essential." Highly rated skills on that scale included knowledge, honesty, speaking clearly and taking time to answer questions.¹

A survey conducted of American Society of Clinical Oncology (ASCO) attendees in 1998, demonstrated that only 6% had received any formal training in delivering bad news. Additionally, they ranked their skill at discussing bad news as poor to fair.² A 2006 article by Arnold and Koczwara³ highlighted that good communication skills can be taught; however, they need practice and refining. In a structured setting, with a facilitator, peers and a patient-actor, there is opportunity for feedback. Also, different techniques can be practiced utilizing the same clinical scenario. In general terms, simple observations by senior practitioners in unstructured

1. Do your fellows receive formal training in the “giving of bad news?”
- | | | | | |
|----------------------------|--------------------------|------------------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1 | 2 | 3 | 4 | 5 |
| No defined formal training | | Few lectures with mentor education | | Extensive formal training with role-playing in the curriculum |
2. Do you believe that the training your fellows receive in the “giving of bad news” is adequate?
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> |
| 1 | 2 | 3 | 4 | 5 |
| Inadequate | | | | Meets all standards |
3. Do you feel that formal training is important for adequate skill development in regards to the “giving of bad news?”
- | | | | | |
|-------------------------------------|--------------------------|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1 | 2 | 3 | 4 | 5 |
| Formal training not required at all | | Some training useful | | Formal training is very important |
4. Does your institution provide support for formal training in the “giving of bad news?”
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> |
| 1 | 2 | 3 | 4 | 5 |
| No support at all | | Some support | | Full support provided |
5. Do you believe improvements are needed in how your fellows are trained to deliver bad news?
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> |
| 1 | 2 | 3 | 4 | 5 |
| No improvement needed | | Some improvement needed | | Extensive improvement needed |
6. Did you receive formal training in the “giving of bad news” during your fellowship?
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> |
| 1 | 2 | 3 | 4 | 5 |
| No training | | Some formal training | | Extensive formal training |

Demographic Questions:

Where is your program located within the US? (please choose from the list below)

Northeast Southeast MidAtlantic Midwest Northwest Northwest WestCoast Southwest

What setting is your hospital in? (please choose from the list below)

Urban Suburban Rural

Is your hospital a tertiary care hospital? (please choose from the list below)

No Yes

Do you have an NCI designation? (please choose from the list below)

No Yes

How many fellows are in your program?

Please describe your primary teaching hospital.

FIG. 1. Training in delivering bad news survey.

settings and without adequate feedback mechanisms do not allow for skill refinement.

The majority of education in communication skills for medical practitioners occurs in medical schools where there are opportunities for role-play. Teaching communication skills to medical oncology fellows has been explored in a 2003 study.⁴ In that article, the authors described their program to teach communication skills to medical oncology fellows. The program utilized a 4-day retreat to focus on educational goals. Sessions were divided into large and small groups. Small group sessions emphasized role-playing using the fellows as well as patient-actors and faculty facilitators. Fellows agreed to initiate new communication skills in clinical practice while remaining in contact with their facilitators.

The value of good communication skills goes beyond effective communication of information to the patient. Good communication skills enable the practitioner to detect patient distress and to assess and manage pain, anxiety and depression.^{5,6} Good doctor-to-patient communication is essential for patients to understand their prognosis and to make treatment decisions based on realistic expectations. In addition, the importance of good communication in delivering bad news is recognized by national organizations. ASCO included "Breaking Bad News" in its supportive care curriculum and

the National Comprehensive Cancer Network developed guidelines on "Breaking Bad News."

The purpose of this study was to investigate attitudes of hematology/oncology fellowship program directors toward current curriculums utilized to train fellows in delivering bad news.

Methods

A survey was e-mailed to all program directors of the 124 combined hematology/oncology fellowship programs within the United States. Three e-mail attempts were made over 6 months. The e-mail consisted of an introduction to the survey as well as the survey. The survey used a scale from 1 to 5 for program directors to grade their answers to six different questions on the existence, perceived adequacy, institutional support, and importance of training in delivering bad news. It also inquired about the training program directors had received in delivering bad news. Additionally, the survey contained demographic questions (Fig. 1). Surveys completed by program directors were e-mailed or mailed back to the primary investigator. The data from the individual surveys were pooled into a spreadsheet and reported descriptively as percentage of total responses for each individual question.

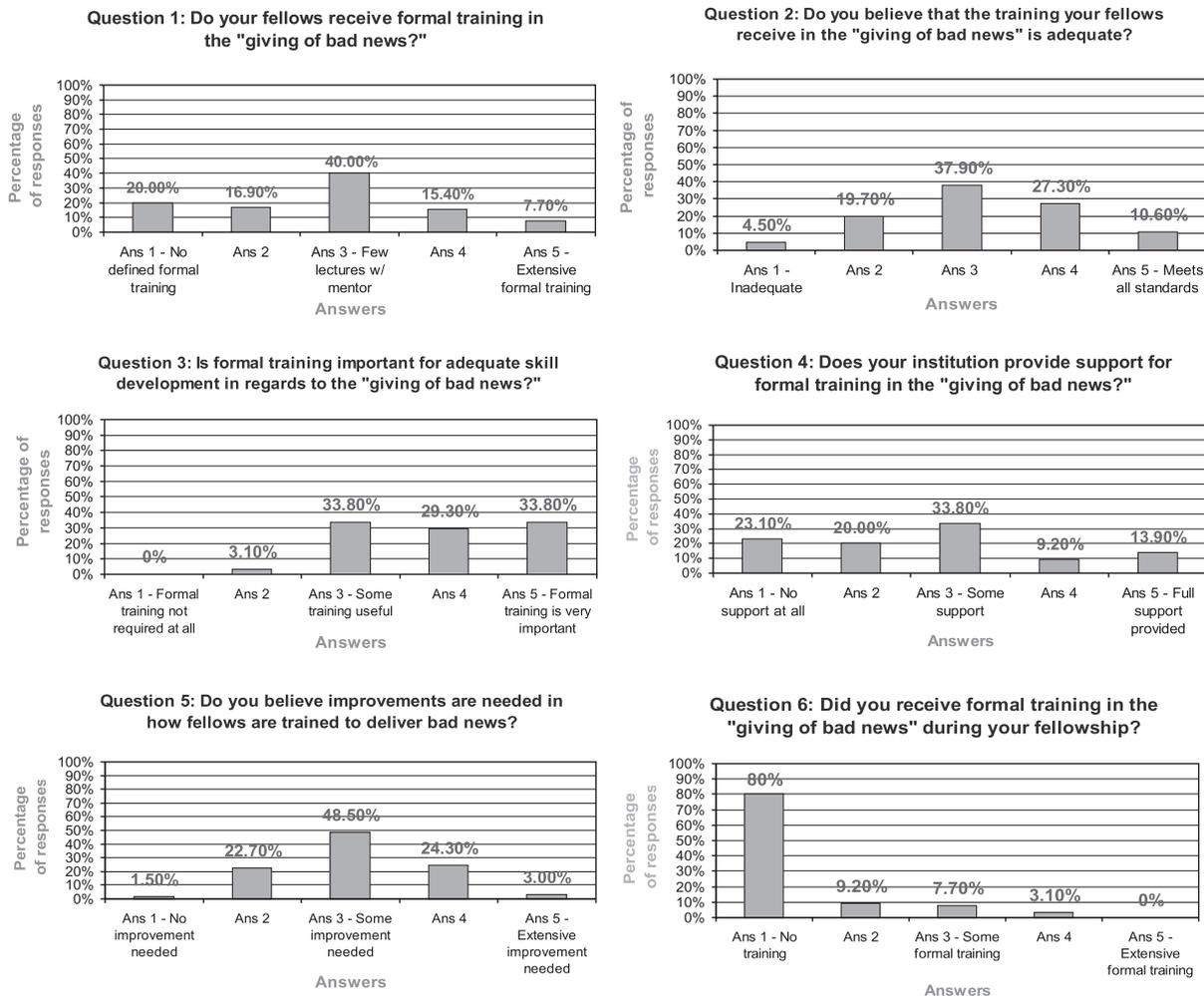


FIG. 2. Survey results.

Demographic data were also reported descriptively. The responses to all the questions in our survey can be graphically seen in Figure 2. χ^2 Statistics were used to perform analytical comparisons between the training received by program directors and the training being given to fellows, and between the perceived importance of the need for training and the institutional support for such training.

Results

After a total of three e-mailings sent out from June 2006 through December 2006, 65 completed surveys (52%) were received and analyzed. Review of demographics revealed that the majority (82%) of programs were located in an urban setting. Ninety-seven percent of the primary teaching hospitals were considered tertiary care centers and 46% of programs carried an NCI designation. The median number of fellows in hematology/oncology training programs was 6 with a range of 3 to 46 fellows (Table 1). Training program locations are outlined in Table 2.

In regard to training in delivering bad news, 89% of program directors reported that they received little to no training during their fellowship. However, they reported that only 37% of fellows receive little or no training. Forty percent of current fellows were reported as receiving some training with the remaining 23% receiving moderate to extensive training in delivering bad news. The difference between the training received by program directors and the training currently given to fellows showed statistical significance (χ^2 38.2; $p < 0.001$; Fig. 3). The majority (63%) of program directors felt that training in delivering bad news is important for skill devel-

opment. Only 3% did not feel that training is necessary. Additionally, 38% of program directors felt that their fellows' training meets most or all standards. Twenty-four percent felt that the training was inadequate and 38% felt that training was somewhat adequate. Similarly, the majority of program directors would like to see improvements in how their fellows are trained. Forty-nine percent of program directors noted that some improvement was needed in their program and 27% noted that moderate to extensive improvement was needed. With regard to institutional support for training in delivering bad news, 43% of program directors reported little to no institutional support while 23% reported moderate to full institutional support. The difference between the perceived importance in "giving bad news" training and the perceived institutional support showed statistical significance (χ^2 30.9; $p < 0.001$; Fig. 3).

Discussion

Giving bad news is not an easy task for anyone, especially early in a physician's career when these conversations can provoke feelings of anxiety and avoidance. The results of this survey demonstrate that great improvements need to be made in how hematology/oncology fellows are trained to deliver bad news.

In general, communication skills need to be taught in order to effectively train fellows in delivering bad news. Currently, teaching communication skills is one of the six competencies that are required as a part of any residency/fellowship training program by the Accreditation Council for Graduate Medical Education (ACGME).⁷

In an investigation by Back and colleagues,⁸ the efficacy of communication skills training was examined using a 4-day retreat to teach communication skills to 115 medical oncology fellows. The investigators observed significant improvements in communication skills in delivering bad news with using standardized patient encounters as an educational tool. Utilization of role-play and retreat style education has also been investigated in other countries. In Australia, oncology communication skills' training was established in 1997 and included role-play.⁹ Delivering bad news is currently a component of their curriculum. The Australians currently provide communication skills training to all trainees nationally.

The value of effective communication skills is significant. In several recent studies, effective communication proved to be a vital tool for not only discussing diagnosis and treatment, but also for predicting prognosis. In a study by Schnadig and colleagues,¹⁰ patients with advanced colorectal and lung cancers were reviewed in regard to discordances between patient and physician reporting of patient's performance and

TABLE 1. DEMOGRAPHICS OF SURVEY RESPONDERS

Demographic	Number	Percentage
Surveys sent	124	100%
Surveys Returned	65	52%
Location		
Northeast	20	31%
Southeast	10	15%
Mid-Atlantic	4	6%
Midwest	18	28%
Northwest	1	2%
West Coast	4	6%
Southwest	8	12%
Setting		
Urban	53	81%
Suburban	9	14%
Rural	3	5%
Tertiary care center?		
Yes	63	97%
No	2	3%
NCI designation?		
Yes	30	46%
No	35	54%
Number of fellows		
1-5	5	7%
6-10	31	48%
11-15	20	31%
16-20	4	7%
21-25	1	2%
>25	3	5%

NCI, National Cancer Institute.

TABLE 2. SURVEY RESPONDERS BY LOCATION

Location	# of programs in location	# (%) Returned
Northeast	20	12 (60%)
Southeast	12	9 (75%)
Mid-Atlantic	43	15 (35%)
Mid-west	28	16 (57%)
Nothwest	2	1 (50%)
West Coast	10	7 (70%)
Southwest	9	5 (56%)

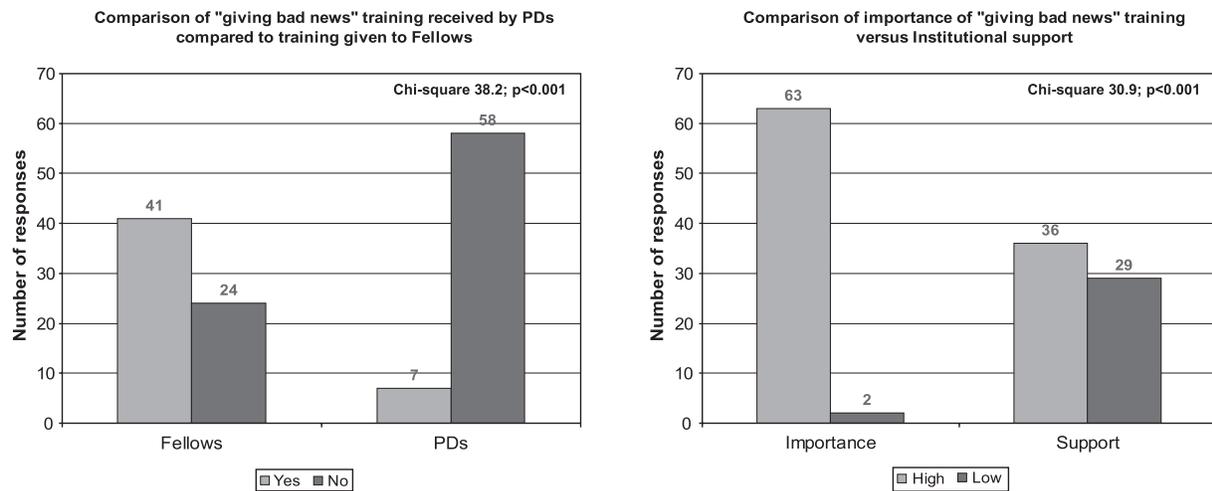


FIG. 3. Statistical analyses.

nutritional status. The results demonstrated that physicians were more likely to rate patients at a better Karnofsky Performance Status (KPS) than patients would rate themselves. In addition, an increased risk of death was seen for patient and physician disagreement on KPS and nutritional status assessments. The study by Dajczman and colleagues¹¹ used a similar design and reviewed patients with advanced non-small cell lung carcinoma (NSCLC) who completed a patient questionnaire designed to mimic Eastern Cooperative Oncology Group Performance Status (ECOG PS) scale. The results revealed that patient and physician estimations of patients' ECOG PS were incongruent nearly 50% of the time. The patient's estimation was a better predictor of survival. Lehmann and colleagues¹² investigated communication of prognostic information to patients with stage IV lung and gastrointestinal malignancies. Physician consultations were audio taped and consultations regarding prognosis were analyzed. Patients were surveyed about understanding of prognosis as well as desire for information about prognosis after their visits with physicians. Results demonstrated that the majority of physicians (78%) communicated information regarding the incurable nature of the malignancy; however, only a minority of patients (32%) understood this information. Physicians need to be armed with effective communication skills in order to appropriately triage patients in regards to prognosis, which can potentially impact decisions on the administration of chemotherapy and eligibility for enrollment in clinical trials.

The results of this survey show that from current program directors to current fellows improvements have been made in the training in delivering bad news. Eighty-nine percent of program directors received little or no training in delivering bad news compared to only 37% of current fellows. This is likely a multifactorial phenomenon; on one hand, regulatory organizations such as ACGME are promoting such training and, on the other, practitioners understand the need of stronger physician-patient relationships. However, there is still room for improvement. Most program directors (63% of respondents) recognize this training as a useful skill for fellows as trainees advance in their careers. Additionally, 76% of program directors want to see improvements in this training within their institutions. Our study shows that, despite the

perceived importance that giving bad news has, institutional support is lagging behind as 43% of program directors reported little or no institutional support. Further research is needed to clarify whether the lack of institutional support is a roadblock to progress for communication skills' development. We did not ask program directors specifics in regards to institutional support. A future study could try to determine whether the financial support from the institution influences program directors perception on how effectively fellows are trained in delivering bad news.

Our study, however, has limitations. Although the survey was mailed to 124 program directors, only 65 (52%) answered, raising the concern for a lack of interest in the topic. If this were the case, then our conclusion that the program directors want to see improvements in this communication skills training would be weakened if others responded. More likely than not, failure to fill out the survey was secondary to time constraints. We believe that if the remaining program directors would have answered, similar results were likely to have been collected. In addition, most responding program directors were from urban, tertiary care centers. As a result, our conclusions pertain most to the attitudes of program directors from this demographic.

Conclusion

Effective communication is the foundation of a strong, trusting relationship between patient and physician. It is the responsibility of the physician to understand individual patients' medical diagnosis in the background of their psychosocial situation. Only when this is done effectively will the physician be able to appropriately discuss prognosis, prescribe treatment, deliver bad news and discuss end-of-life care with their patients. The training in communication skills begins in medical school, but should not stop there. As physicians advance through training, communication skills need to be reinforced and tailored to the appropriate settings. We hope the present study, with its specific limitations, will serve as a precedent in order to strengthen the perceived need on improving or implementing formal training on giving bad news. With institutional support and further research, hematology/oncology fellowship programs should strive to

advance towards a communication skills curriculum that focuses on discussing prognosis and treatment, giving bad news and handling transitions to palliative care.

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