Barriers to breaking bad news among medical and surgical residents

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Introduction Communicating 'bad news' to patients and their families can be difficult for physicians.

Objective This qualitative study aimed to examine residents' perceptions of barriers to delivering bad news to patients and their family members.

Design Two focus groups consisting of first- and second-year medical and surgical residents were conducted to explore residents' perceptions of the bad news delivery process. The grounded theory approach was used to identify common themes and concepts, which included: (1) guidelines to delivering bad news, (2) obstacles to delivering bad news and (3) residents' needs.

Setting McMaster University, Hamilton, Ontario, Canada.

Subjects First- and second-year residents.

Results Residents were able to identify several guidelines important to communicating the bad news to patients and their family members. However, residents also discussed the barriers that prevented these guidelines from being implemented in day-to-day practice. Specifically, lack of emotional support from health professionals, available time as well as their own personal fears about the delivery process prevented them from being effective in their roles. Residents relayed the need for increased focus on communication skills and frequent feedback with specific emphasis on the delivery of bad news. The residents in our study also stressed the importance of processing their own feelings regarding the delivery process with staff.

Conclusions Although most residents realize important guidelines in the delivery of bad news, their own fears, a general lack of supervisory support and time constraints form barriers to their effective interaction with patients.

Keywords *Communication; education, medical; emotions; family; patient care, *psychological, standards; physicians, *standards.

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Introduction

There is a need for effective communication in health care. This is especially salient for patients facing a frightening diagnosis and an uncertain future for themselves or for family members. Although many health care professionals deliver 'bad news' on a daily basis, most feel uncomfortable and relatively unprepared for the interaction. In most circumstances, the delivery of bad news is a life altering experience for patients and families. Therefore, physicians at all stages of their careers should endeavour to relay 'bad news' to patients with the utmost sensitivity.

Bad news has recently been defined in the medical literature as pertaining to situations where there is either a feeling of no hope, a threat to a person's mental or physical well being, a risk of upsetting an established lifestyle, or where a message is given which conveys to an individual fewer choices in his or her life.[1]

There have been two studies, which have attempted to address residents' perceptions of delivering bad news.[2,3] These previous studies were based on quantitative research designs and used surveys to collect data. Residents were found in these studies to experience discomfort with psychosocial issues related to the conveyance of 'bad' news. Moreover, few residents met published guidelines for doctor–patient interaction when they prepared patients for potentially threatening procedures. While these studies revealed the residents' uneasiness in the delivery process, no additional information regarding the barriers to delivery was reported.

Given the paucity of literature on residents' attitudes and relative 'preparedness' towards the delivery of 'bad

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Key learning points

Medical students are generally aware of the guidelines for delivering bad news.

Personal as well as institutional barriers and differing perceptions of bad news were identified as important barriers to breaking bad news.

Residents reported their numerous role expectations and indicated that specific training and hospital supports were needed.

news', the purpose of this study was twofold: (1) to examine further residents' perceptions on the delivery of bad news with specific emphasis on institutional and personal barriers, and (2) to identify potential areas of focus in postgraduate medical training.

We chose a qualitative research design, which allowed for candid and in-depth responses from the residents. Moreover, a qualitative design permitted greater time for the residents to express their beliefs or opinions. Additionally, a qualitative research approach ensures completeness of the information retrieved rather than leaving out important (and sometimes vital) opinions or aspects of its subjects. The strength of qualitative research enabled us to conduct focus groups and permitted flexibility to address other concerns or issues that had not been previously explored.

Methods

Subjects

Residents from the McMaster University School of Medicine, Hamilton, Ontario, Canada were interviewed regarding the delivery of bad news to their patients or their patients' families. To achieve 'representativeness of concepts' from this phenomenon under study, purposeful sampling was used to select the residents.[4] In order to assess whether curriculum changes concerning training in the delivery of bad news are required and at what point in this training should these changes be implemented, the views of both first year and second year residents from various subspecialties were sought.

We initially interviewed 40 residents from various subspecialties at a single hospital site to identify those who were in their first or second year of training. Of those interviewed, only 20 were eligible to participate in the focus group. Five residents did not consent to participate in the focus group leaving a total of 15 residents for the study.

Two focus groups were conducted in an attempt to identify trends and patterns in perceptions. The first focus group contained seven participants, representing four medical disciplines: family medicine, internal medicine, general surgery and emergency. Four of the members were female; three were male. Four participants were first-year residents and three were second-year residents. The second focus group was composed of a total of four medical (two family medicine and two internal medicine) and four surgical residents of which four were first-year residents (two surgical, one internal medicine and one family medicine) and four were second-year residents. Four of the residents in the second focus group were female.

Procedure

Residents participated in a semi-structured, in-depth interview lasting approximately 1·5 h. This interview was conducted in a private room located in a hospital setting. Two facilitators asked open-ended questions regarding residents' views and experiences concerning the delivery of bad news. A sample of prepared questions asked were: 'What is bad news?', 'What sorts of things do you think patients and family members would consider as bad news?', 'What are the things you most need to learn about delivering bad news?', 'Imagine you are the patient or family member – How would you want the doctor to deliver the bad news?' and 'What are your greatest fears about delivering bad news?'.

Interviews were tape recorded and transcribed verbatim. Two of the authors independently examined, coded and analysed the transcriptions in an attempt to reduce any bias. For reliability, comparisons were made between the two authors. Any discrepancies were resolved through discussion.

Data derived from the two focus groups was coded and the content analysed according to the canons and procedures of the grounded theory approach to qualitative research.[4,5] Table 1 summarizes the canons of the grounded theory method. In this approach, 'a grounded theory is one that is inductively derived from the study of the phenomenon it represents. It is discovered, developed and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon'.[6]

The authors of this study used the analytic process of coding which is consistent with the grounded theory design. Three types of coding were employed. Initially the data, through the process of open coding, was broken down, named and categorized. Axial coding was

Table 1 Summary of canons from the grounded theory approach

1. Data collection and analysis are interrelated processes
2. Concepts are basic units of analysis not the actual data *per se*.
3. Categories must be developed and related.
4. Sampling proceeds on theoretical grounds in terms of concepts, their properties, dimensions and variations.
5. Analysis makes use of constant comparisons.
6. Patterns and variations must be accounted for, that is, the data is examined for regularities and irregularities.
7. Process must be built into the theory by: (1) breaking a phenomenon down into stages, phases or steps and (2) noting purposeful actions/interactions.
8. Writing theoretical memos is an integral part of doing grounded theory research.
9. Hypotheses about relationships among categories should be developed and verified as much as possible during the research process.
10. A grounded theorist need not work alone. Discussion with other researchers working on the same topic under study is encouraged.
11. Broader structural conditions such as economic conditions, cultural values, political trends and social movements must be analysed, however, microscopic the research.[2]

Table 2 Guidelines to delivering bad news

Verbal delivery
Language
Validating
Something tangible
Empathy
Clarify role
Summary

Non-verbal delivery
Face to face
Sitting down
Time

Supportive measures
Assessing supports
Judging family's reactions
Choice
Questions
Finding common ground
Patient's comfort
Accepting outcome
Exhausting all options
Pro-active in treatment

then utilized to put the data back together in new ways. This was accomplished by making connections between categories and their subcategories. Lastly, by means of selective coding, categories were integrated to form a grounded theory. Coding and content analysis of the interview data was performed by two independent reviewers.

Residents tended to provide personal narratives in response to specific questions; therefore, responses were often not linked directly to the questions asked. For example, narratives regarding personal experiences of delivering bad news were reported to the question, 'What are your greatest fears about delivering bad news?'. Consequently, responses to all the questions asked during the interview were combined for purpose of these analyses.

Results

By organizing associated concepts into unifying subcategories, the identification of categories and the discovery of relationships between these categories, a framework of results was developed. This framework consisted of three major categories, nine subcategories and 53 concepts (Tables 2, 3, 4).

The first major category contains information regarding medical residents' perceptions surrounding the proper guidelines for delivering bad news to patients and to patients' family members. The second major category describes medical residents' views regarding obstacles, both personal and institutional, to delivering bad news appropriately. The third major category contains issues pertaining to medical residents' needs in a hospital setting which ultimately effect the facilitation of delivering bad news.

Table 3 Barriers to bad news delivery

Residents' fears
Making mistakes
Not being prepared
Shame in asking for support
Personal attachment to the news
Awkwardness
Nervous
Stress
Telephone delivery
Confrontations
Being misunderstood
Unable to follow up

Discernments regarding bad news
Prolonging life or death
Biases
Stigmas
Unusual circumstances
Uncommon reactions
Continuum of loss
Patient or family instinct(s)

Institutional barriers
Lack of support
Time constraints

Table 4 Addressing resident's needs

Training
Best approach
Observation
Reform
Explore attitudes toward death and dying
Hospital supports
Multidisciplinary team
Time to prepare
Time to process
Resident's roles
Messenger
Expert
Hero
Martyr
Agent of change
Primary care provider
Team player
Machinist

Category 1: Guidelines for delivering bad news

Our first category entitled 'Guidelines for delivering bad news' included the clinical tools or strategies residents used in order to convey the difficult news (Table 2). The guidelines were broken down into three subcategories which consisted of verbal delivery, non-verbal delivery and supportive measures.

Verbal delivery The majority of the respondents were aware of previously reported general guidelines of delivering bad news to patients and their patients' families.[1] The residents stressed the importance of language as a key element in effective delivery. The language used to the patient or family must be simple and direct as one participant stated:

> 'I always say die. I always say it bluntly. I never say passed away because I had an episode where someone did not understand what I was saying.'

A number of the residents agreed that using unclear language resulted in confusion and misunderstanding for the patient and their families. Additionally, to minimize confusion among caregivers and patients, the residents indicated the importance of identifying their roles and offering something tangible, such as results from tests, to the receivers of the news. Residents also supported showing patients and families empathy – a response which could include normalizing or validating the impact of the news on the patient or family.

Non-verbal delivery We found that residents agreed that non-verbal delivery, such as sitting down, face to face discussion and adequate time were essential in conveying bad news. These gestures complemented the verbal delivery of the news and were felt to reflect an empathic response by the residents.

Supportive measures Supportive measures were perhaps the hardest of the guidelines to follow. Supportive measures are based on assessment and formulation skills. These measures required the residents to deal with patients' or families' emotional needs after the news has been delivered. Medical training has focused on the skill in obtaining information rather than giving information to patients and families on how to cope with difficult information.[7] It makes sense, therefore, that these residents struggled over this section.

The residents appeared divided over the most difficult type of measure to implement. A couple of the residents identified that judging and responding to the family's or patient's reaction was particularly difficult. As one respondent indicated:

> 'Sometimes it's fearful because you already have a family that you know is quite litigious or unapproachable so you are always afraid in those situations… am I going to say something that's really going to sets things off.'

Other residents indicated that honouring the patient's or the family's choice concerning treatment was troublesome and sometimes complicated:

> 'I guess that's where you start towing the fine lines … are they capable of making that choice or are they suffering with depression or something else that really needs to be treated and that's where it really gets tricky.'

Other supportive measures included establishing the patient's comfort, exhausting all resources or options, being proactive in treatment, and accepting the outcome of the prognosis or treatment.

The guidelines that were offered by the focus group were consistent with some of the existing literature concerning difficult news delivery.[1,8] The literature is, however, varied in terms of the best approach. This dilemma resulted in some of the residents being confused as to the best approach to take when conveying the news:

> 'I guess that brings up to what are the best ways to do this? I heard those who say you should just go and, you know, say so and so has just died rather than trying to approach by saying that someone passed away or died, whatever, but then I heard other people say you should lead up to it.'

Although the residents were aware of the guidelines, they experienced difficulty in applying them in clinical

practice. According to the residents, the chaotic hospital environment, their own personal fears and the patients' reactions hindered the implementation of these guidelines. These obstacles resulted in only partial adherence to the guidelines.

Category 2: Obstacles to bad news delivery

This major category includes what was identified in the analysis of the data as the medical residents' views regarding obstacles that block the effective and compassionate delivery of bad news in a hospital setting (Table 3). The personal and professional experience of medical residents regarding this phenomenon has seldom been addressed in the literature. Findings for this category are divided into three subcategories: discernments regarding bad news, residents' fears and institutional barriers.

Discernments regarding bad news Residents noted numerous types of intrinsic factors that affected the appropriate delivery of bad news. Differing perceptions between the resident and the patient or the patient's family members, in regard to what constitutes bad news, had been cited as a factor by the residents in our study. This supports the concept that the perception of bad news is highly subjective and may differ greatly depending on one's role in the communication either as the bearer or the receiver of bad news.[1]

Some level of emotional pain to the patient usually accompanies the delivery of bad news. The duration and intensity of these emotions may vary however, depending on whether the resident and the patient agree about the nature of the bad news.[1] Residents in our study suggested that their own biases, or the associated stigmas regarding particular illnesses, influenced their perception of the news.

> 'I sort of have a real problem with this. I think a lot of us have our own biases on certain illness and on certain conditions and states of patients.'

A resident's personal bias might well leave him or her unprepared for a patient's or family member's reaction that appears uncommon. Moreover, residents also noted that there is a continuum of loss (for example, broken leg vs. amputation or death) which effects the awfulness of the news. Bor *et al.* stress the importance of physicians waiting for the patient to make a judgement as to whether the news is good or bad before forming their own opinions.[9] Many of the residents expressed the idea that opinions between themselves and their patients regarding bad news may differ; however, none of the residents mentioned suspending judgement until the patient's reaction had been assessed. This is of prime importance since dire medical predictions and harmful attributions by physicians are strong enough to affect not only the duration and intensity of emotions but also create anxiety, fear, depression and resignation in their patients.[10]

Residents, as well as established physicians, tend to have a strong orientation toward cure. Residents stated that they felt the need to, 'do something or feel like you are making a change or an effect' and to 'save lives at any cost'. Others, however, were struggling with the dissonant views emerging from the field of palliative care. One such resident expressed it best by saying, the family of one of her patient's:

> 'had it right when they came in and said, look, I think we crossed that bridge here. We are no longer prolonging this individual's life but we are prolonging their death.'

When physicians are faced with a situation that they cannot remedy, they often feel ineffective and powerless.[8] These feelings may result in the physician limiting their relationship with the patient or the patient's family members to areas that they feel comfortable.[8] This concept of limiting the relationship between physician and family members is reflected in the thoughts of one resident:

> 'do you just walk in and say, okay they died and I am sorry and there is nothing else we can do and walk out?'

Residents' fears Residents reported stress in dealing with, and responding to, patients' and their family members' reactions to bad news. This concept was frequently noted by residents in our study.

> 'Not being prepared for the outcome afterwards. It is … cleaning up afterwards and dealing with their reactions which is most uncomfortable, I think.'

According to the residents in our study, telephone delivery of bad news made it especially difficult to respond to, and follow up with, patients' and family members' reactions. Additionally, residents also expressed other fears such as being perceived by their patients and patient's family members as uncaring or as not being empathic. This misunderstanding of affect was reflected in the comments of one the residents:

> 'It is my fear that they won't think that I'm caring… and that I'm not empathic enough.'

Uneasiness with death and dying is cited in the literature as being of concern for physicians. Only one resident expressed views regarding this topic, which were:

> 'I mean we have to be comfortable with our own concepts around death and dying… We have to look at our own values around that.'

Incidentally, immediately following this statement, the topic was abruptly changed, possibly indicating discomfort with this subject matter. Awkwardness with death and dying can block the appropriate delivery of bad news.

Institutional barriers Institutional barriers are obstacles in the hospital setting that block an appropriate delivery and are structural and/or systemic in nature. Inadequate amounts of time in various contexts was mentioned most frequently in our study as an institutional barrier to the appropriate delivery of bad news. The following illustrates this concept.

> 'Sometimes there isn't the time, they [patients] don't have the luxury [of time] nor do we.'

Inadequate amounts of time to prepare oneself, the content of the informing interview and the processing of various emotions after the delivery of bad news were reported as significant impediments by focus group participants. This was best summarized by a resident who said,

> 'The way our system works we don't have time to take 10 [minutes] out and have a coffee and… to grieve for the losses of our patients' regardless of how brief the contact or what the setting is. But somewhere along the line these things are in our experience base and they need to be dealt with.'

This lack of adequate time is more prominent in acute hospital settings where, often, life and death decisions need to be made instantaneously. Time for reflection appears to be, however, an extravagance in both the acute-care hospital setting and the chronic-care hospital setting.

Not having adequate support from other members of the hospital institution was also repeatedly named as a barrier by the residents in our study. Residents described the need for support from their colleagues, from their supervisors and from other health-care professionals. Support from others was mentioned as being 'important' both during the informing interview and afterwards. Members of our focus groups suggested that, not only do patients' and family members need support, but the residents themselves as well.

Institutional barriers not only affect the delivery of bad news from the residents' perspectives but also have dire consequences for services offered to patients and their families. Residents noted that time is not available to provide such needed services as, viewing the deceased patients' body with family members.

> 'Often times people want to go see their loved ones and make sure they are not breathing and don't have a pulse. Unfortunately, … it doesn't work out that way. Because of time, you got 40 other people waiting in your emergency room. Our system doesn't necessarily allow adequate… or ideal care at the moment.'

The defence mechanism of denial is used by most people when initially given bad news, to alleviate what appears to be senseless, unexpected pain and possible loss. Many residents in our study were familiar with the process of denial experienced by patients and/or family members. Immediate life or death decision making plus heavy caseloads which impede residents' from allowing patients and/or family members adequate time to absorb their reality, were cited as factors interfering with the normal process of denial.

Category 3: Addressing residents' needs

Our final category of addressing residents' needs emphasizes the tools residents require in order to provide quality health services (Table 4). We wanted to acknowledge the needs of residents that are often ignored within hierarchical hospital structures. The focus of the discussion pertained to changes in training, hospital supports and the different roles residents are required to play.

Changes to training During the focus groups, the residents were able to come up with clear suggestions that would improve their news delivery within a hospital setting. The majority of the residents concluded that training needed to emphasize the most appropriate manner in which to deliver news depended on the context of the situation. This training should focus on the similarities and differences of bad news delivery between chronic and acute care settings. The residents also suggested that direct observation of staff physicians was helpful but that there needed to be more opportunities to process their interaction, ask questions and receive staff feedback after the news had been delivered. In addition, some of the residents stressed the importance of exploring attitudes toward death and dying in their training. Many of them believed that this exploration would allow them to examine their own biases.

Hospital supports The residents noted the significance of hospital supports to their training. Hospital supports are those services, provided within a hospital, that

residents might access for emotional support. The residents in our study advocated for a multidisciplinary team approach to conveying difficult news. In a study conducted by Lord *et al.*, 70% of clients preferred that social workers be present when the doctor breaks bad news.[11] Residents concluded that team medicine benefits them and their patients. This team approach would allow the residents more time to prepare and process their own emotions regarding the situation of their patients and patients' families.

> 'That's why I really think it is important, at least for me it's important, to have another caregiver, whether it be a nurse or a social worker, who can hear the same words you are saying and who is not emotionally tied to the situation so they are processing mentally everything that has been said and they can follow it up…'

> 'I think they could certainly serve both our needs in terms of the anxiety issue, especially in the emergency setting.'

Roles Residents play a variety of roles when they deliver bad news. Some of the residents were very clear of their roles as the messengers:

> 'I think part of the key is recognizing that you are the messenger and often times we are going to get shot.'

This resident articulated the consequence of this role during news delivery. Other residents experienced the pressure of having to play the roles of either the experts or heroes. The reality of the situation suggests that residents cannot save all their patients nor have all the information for the families. This former is not always an easy compromise. The most common role the residents described was one of a machinist.

> 'All of the sudden we are telling the family… and so we tell the family and the next thing you know we're walking out and picking up the next chart and going. But where's our process in that? When do we come to resolution? It's so easy to feel awkward, like wait, I just told somebody that he's dead… now, hi I am Dr – …what brings you to the hospital today?'

The hospital structure allowed little time for the residents to process information. As a result, residents continued seeing patients as if they were on an assembly line of some sort. The residents in our study were interested in being perceived as members of a team. The role of team player would then reduce some of the isolation they experience when they break bad news.

Discussion

Intuitively people know that health has to do with wholeness. Patients and their family members want physicians who care about them as whole beings not only when they are well but, more importantly, when they are ill. Residents from our study want to be perceived as caring and empathic by their patients and patients' family members. Our three major categories yielded some interesting results that may help residents when delivering bad news. We recommend the need for the removal of barriers, a shift in paradigm and medical curriculum reform as three key components for the empathic delivery of bad news.

Removal of barriers

This study has shown that residents are aware of the general guidelines to delivering bad news but they experienced difficulty when applying them in practice. We identified two studies, which focused upon surgeons' interactional skills with patients.[2,3] In the first study, 21 surgical residents were rated on their ability to break bad news and discuss potentially life-threatening surgical procedures with patients.[2] Of those 21 residents involved in the study, none were able to deal appropriately with psychosocial issues relating to patient care. Moreover, when the news about a patient's prognosis was bad, only 10% of residents gave support to the patients. In a second study, 143 surgeons were surveyed regarding their skills in patient communication.[3] While only 13·3% of surgeons reported a lack of confidence in breaking bad news to patients about their diagnosis or prognosis, a significantly higher proportion of surgeons (59·6%) felt uncomfortable with bereavement counselling. The results of these studies support our findings regarding the difficulty residents experience with having to implement supportive measures. At the same time, however, these studies were unable to address the barriers that prevented the residents from following the guidelines. The barriers, both personal and institutional, that residents face create inconsistency with implementing the guidelines. Additionally, these barriers prevented residents from having their own learning and emotional needs met.

Residents cited time constraints and lack of support from other health professionals as being the two main factors in terms of institutional barriers. These factors affect an appropriate delivery of bad news and they interfere with other consumer-focused services such as, lending assistance while family members' view the deceased patient. Moreover, these institutional barriers feed into the residents' personal barriers. For instance,

both time constraints and lack of support from colleagues does not allow the residents to process their own emotional attachments to their patients or patients' families. Additionally, without processing their feelings or actions, residents may feel anxious if they have to deliver similar news again. This situation plays on their lack of confidence, which was another personal barrier cited by the residents.

In Canada, $80 billion per year is spent on health care. Canadians, however, are increasingly critical of perceived defects in the health care system. Removing institutional barriers and increasing health care funding may allow health care professionals to provide service, and to deliver it in a compassionate and empathic manner.

A paradigm shift

Considerable attention has been given to the content and the context of the informing interview. Only two studies cited in the literature, however, concern themselves with the importance of the affective manner by which physicians convey bad news.[1,7]

Emphasis in conventional western medical training is placed on the biochemical paradigm. Using this paradigm, healers treat defects, pathologies and disabilities in a very mechanistic manner. The body is seen as a compilation of parts and, when ill, is treated by a parts 'specialist', the physician. This mechanic role was reflected in the comments voiced by the residents in our study. Canadians, in record numbers, are seeking alternatives to conventional medical treatment. One possible suggestion given for this trend is the holistic approach to healing that many alternative treatments profess. A holistic approach is concerned with the body, mind and spirit. It is dehumanizing to treat patients as body parts void of any humanness.

Delivering bad news is not a technical skill where a script is learned by the residents. Bad news delivery should include an emotional connection or response. Instead, residents may distance themselves from their patients or their patient's family members, to protect themselves from the anticipated emotional pain of others. Residents may also emotionally and physically distance themselves to avoid the manifestation of that emotional pain. Spending as little time as possible with angry or distraught patients' or family members' may possibly be a protection mechanism for residents. If, however, residents were supported by other staff, perhaps they would allow themselves to connect more with their patients and patients' families.

Residents in our study favoured a multidisciplinary team approach to delivering bad news. This team medicine approach not only works with the patients and their families but also serves as an emotional support for health professionals. This support would allow residents an opportunity to process their own reactions to the news delivery. In addition, a team approach would also reduce the number of roles the residents would play, thus allowing them greater opportunity to develop some of their communication skills by learning from other disciplines. Team medicine is an asset in reducing both the personal and institutional barriers that residents experience in bad news delivery. Moreover, once the barriers have been removed, residents are then able to follow the guidelines, including the implementation of supportive measures, in a more effective manner. The end result of this process is quality service for the patients.

Medical curricula reform

Traditional medical education, as reflected in the narratives of the residents in this study, is ineffective in teaching clinical communication. There is extensive variability in the quality and intensity of the courses offered.[12] Traditionally, under the apprenticeship model, complex clinical skills have been acquired by observation of seniors and by practise, not always observed by seniors, followed by feedback.[13] Sometimes, in the interest of time, residents are not provided with feedback. Furthermore, the approaches by seniors to delivering difficult news may vary greatly, leading to more confusion for the residents concerning the best approach.

Findings from this study indicate that residents want to learn how to be beneficial clinical communicators. A former study has indicated that, in order to be a beneficial clinical communicator, physicians must master a specific body of knowledge, skills and attitudes.[14] Knowledge of psychiatry as it relates to medicine, and the structure and functions of medical interviewing are suggested as relevant areas where residents should acquire skills. The authors of this study would also include knowledge of the issues surrounding death and dying as another required area. Simpson *et al.* suggest that skills needed within the interview are those of data gathering, forming and maintaining relationships, dealing with difficult issues and imparting information, as well as therapeutic skills and strategies.[14] Findings from this present study lend strength to these postulates. Simpson *et al.* also suggest that a belief in the importance of a biopsychosocial perspective and an unconditionally positive regard for patients are also required if physicians are to be beneficial clinical communica-

tors.[14] We feel that the residents should accept that death is an integral part of life and not some foe that can always be conquered.

Murray *et al*. have stressed the importance of evaluation of which teaching methods enhance student learning in different settings.[15] This point is critical in regard to the different learning needs for residents in acute vs. chronic care settings. Residents needs have to be placed on the agenda of learning to deliver bad news.

In conclusion, residents identified several important barriers to breaking bad news including personal fears, differing perceptions of bad news, and institutional barriers. These barriers may be overcome with increased skills training for residents, a stronger support network of peers and supervisors, and fewer constraints of time when delivering the news.

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Contributors

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