The Impact of Senior Medical Students’ Personal Difficulties on Their Communication Patterns in Breaking Bad News
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Abstract

**Purpose**
To evaluate the possible influence of personal difficulties and barriers that are within the news bearer and his or her self-awareness (SA) of them, on the patterns of communication during encounters involving breaking bad news (BBN).

**Method**
Following an intensive BBN course in 2004, 103 senior medical students at the Sackler School of Medicine, Tel Aviv University, were evaluated for BBN competencies by the analysis of their written descriptions of how they visualized their manner of delivering bad news to a patient described in a challenging vignette. The students were further asked to reflect on their own difficulties and barriers that surfaced in response to reading the narrative presented in the vignette and in delivering the bad news. Using an immersion crystallization narrative analysis method, the authors analyzed the relationship between the students’ BBN strategies and their self-perceived barriers and difficulties.

**Results**
Four types of communicators were identified and related to 45 different personal and professional barriers that the students, through self-reflection, found in themselves. These perceived barriers as well as the ability to self-reflect on them influenced their patterns of communication in their envisioned and written-down encounters, including the level of emotional connectedness, information provided, and the chosen focus-of-care paradigm (physician-centered, patient-centered, or relationship-centered).

**Conclusions**
These findings empirically demonstrate that intrapersonal difficulties within the communicator and his or her level of SA about them influenced the manner and content of the communication during the encounter. This finding suggests that enhancing SA and addressing personal and professional difficulties could help physicians’ capability to cope with challenging communication tasks. The authors propose a working tool (the Preparatory SPIKES) to facilitate the integration of self-reflection (by identifying personal difficulties) into day-by-day planning and delivery of bad news.


In recent years there has been an increased interest in enhancing physicians’ communication skills in general, and in breaking bad news (BBN) in particular. As a part of this, educators suggested the need to discuss and enhance self-awareness (SA), given its potential effect on communication and quality of care. Even though time and effort have been devoted to enhancing SA, using different strategies, the actual way that personal difficulties and SA influence communication has not been widely explored and determined. The present study aims to fill this gap of knowledge by empirically examining the relationship between medical students’ written self-reports of personal difficulties arising within them in response to reading a challenging vignette about a patient to whom bad news is about to be delivered, their level of SA of these difficulties, and their communication style/type. In this report, we identify the typology of communication patterns related to the personal difficulties expressed by students and describe a working tool (the Preparatory SPIKES) to facilitate the integration of self-reflection (by identifying personal difficulties) into day-by-day planning and the delivery of bad news.

The diagnostic-disclosure encounter infrequently involves a patient’s receiving bad news from his or her physician. In such cases, it constitutes an emotionally highly charged event in the journey of patients with serious illness. It is a critical juncture in patients’ relationships with their health care providers and, consequently, in patients’ adherence to treatment. Enhancement of the news bearer’s BBN skills has therefore become an integral part of the curricula for the training of health professionals, and general guidelines have been developed for BBN communication including preparation of the encounter, establishment of an appropriate environment, and the actual manner of disclosure.

Such instructions and guidelines may not in themselves ensure the acquisition of adequate skills. Although brief training may be effective in teaching interactional skills, data are sparse regarding successful transfer into practice or sustainability of improvements over time. Some studies indicate that the ability to acquire new skills is mediated by learners’ emotions and belief in the...
necessity of these skills, on the one hand, and their negative attitudes toward unfamiliar skills on the other. As defined by preservation of meaning and purpose in personal growth, confidence, and these issues after difficult interviews. In practice, physicians’ personal characteristics, past experiences, values, culture, attitudes, beliefs, biases, emotions, emotional “hot buttons,” expectations, conscious and unconscious assumptions, and needs have an important impact on communication with patients. Another important factor is presence (being wholeheartedly in the encounter) or distraction in the course of the encounter. Awareness of these issues and the ability to cope with them have been shown to enhance communication efficacy.

The exceptionally demanding nature of bad-news disclosure highlights the need for attention to perceived barriers within the disclosing. These include a perceived need to “rescue” the patient; a sense of failure, frustration, and powerlessness in the event of inexorable adverse illness progression and its associated losses, grief, and fear of becoming ill oneself; and a not infrequent desire to distance oneself from and avoid patients’ feelings. Other potential barriers include inadequate support and/or supervision from peers and mentors as well as limited opportunities to discuss these issues after difficult interviews. These findings have stressed the need for an enhanced level of SA as a means for personal growth, confidence, and preservation of meaning and purpose in physicians’ work. As defined by Novack et al., SA is an “insight into how one’s life experiences and emotional make-up affect one’s interactions with others.”

We carried out the present study to evaluate empirically whether personal difficulties and SA influence the communicator’s patterns of communication, and how. In will:

1. list issues in the narrative that might require special attention while delivering the news;
2. provide a step-by-step narrative description of how they would prepare for and actually deliver the news (using the SPIKES protocol, in a conversational manner), including their predictions of possible reactions of the patient and their own responses; and
3. describe their personal barriers and difficulties that were evoked by the narrative and their subsequent disclosures in responding to the second instruction above, and suggest possible ways of coping with them.

In this report, we analyze the interactions between students’ responses to the second and third instructions, that is, how the SA reflected by their
identification of personal barriers and difficulties influenced the course of the bad news disclosure encounter.

The SPIKES protocol

Because of the importance of the SPIKES protocol in the course, test, and analysis, we now briefly describe its components. SPIKES is a protocol for communication of bad news and consists of six steps²⁶:

- **S**: Setting up the interview, including preparing and planning of the space, the presence of others, the seating arrangements, and managing time constraints and interruptions
- **P**: Assessing the patient’s Perception—finding out how the patient perceives the medical situation
- **I**: Obtaining the patient’s Invitation to the type and depth of information they want to receive
- **K**: Providing Knowledge and information to the patients—sharing the information with the patient in a tailored level of communication and vocabulary
- **E**: Addressing the patient’s Emotions and Empathic responses—responding to the patient’s emotions with empathy
- **S**: Strategy and Summary—planning the next steps, setting goals and treatment plans, and establishing follow-up

Analysis

All the written answers on the test regarding the personal difficulties experienced by the 103 students were coded and entered into an SPSS file. This was done by content analysis based on iteration consensus (qualitative intrarater reliability; see also Taylor et al in *The Mouton Handbook in Applied Linguistics*, vol. 3, C. Candlin and S. Sarangi, eds, Berlin, Mouton de Gruyter, in press), that is, repeated discussions between the primary analyst (O.K.M.) and two research assistants (S.H., E.L.) to achieve agreement in identifying and naming the personal issues raised by the students. The procedure included two steps repeated four times: First, each coder independently highlighted the personal difficulties she recognized in the text and gave them provisional names (such as “identification with the patient” or “guilt due to prior medical decisions”). Next, the coders met face-to-face to discuss what they identified and sought consensus on the actual identification of each difficulty and its name. A codebook of difficulties, which consisted of definitions and an example of each type of difficulty expressed by the students, was developed and refined after each batch of coding. This process was repeated until consensus was reached on identifying and naming the difficulties expressed in the tests. Working with the codebook enhanced the reliability of the coding.

To explore the influence of the students’ personal problems and barriers on communication patterns, a “typology of communicators” was established. This was accomplished by qualitative content analysis of 55 randomly selected tests, 24 completed by men and 31 completed by women, based on an immersion crystallization method. This was a thematic narrative analysis framework, in which the primary analyst (O.K.M.) immersed herself in the data for a substantial concentrated period of time²⁶ and then reflected with “intuitive crystallizations until reportable interpretations” were reached.²⁷ This immersion process involved the following main steps:

- A horizontal analysis: An inductive process of reading, rereading, and learning each student’s script of breaking the news, as a whole and as a narrative, and getting a sense of who they are, what characterizes them, what their concerns are, and what their patterns of communication are. This analysis made it possible to construct a typology of communication and explore the relationship between the type of communication and the participants’ personal difficulties and SA.
- A vertical analysis by the entire research team: This analysis focused on each type of communicator identified in this study to better define each type’s ways of doing and thinking (i.e., differentiating between the types’ motives and modes of behavior). This was done to fine-tune and crystallize the most important aspects of communication²⁸ and the similarities and differences between the four types of communicators identified in the horizontal analysis, and to recheck for alternative hypotheses and interpretations.²⁹ Subsequently, a theory-driven predefined analysis, based on the components of the SPIKES protocol, was formulated to learn how exactly the SPIKES protocol was applied by each type of communicator. This analysis continued until theoretical saturation of the typology of communicators was achieved, that is, when no new patterns were identified in the responses to the tests.

Results

Note: Even though in this report we have provided information concerning the number of students and their distribution by gender, that is only meant to allow the reader to gain a rough sense of the numbers and sexes of the respondents in this data set.³⁰ As is true in most qualitative studies, we aimed to provide information regarding the kinds of things that happened, without precisely estimating their prevalence in the general population.³¹

Types of personal difficulties expressed by the students

The students listed 45 different personal barriers/difficulties that surfaced in response to reading the narrative presented in the vignette (n = 103; mean number of problems [per student] = 3.6, SD = 1.75; range, 0–8 problems).

The personal difficulties identified by the students were classified into the following five major content categories (see also Table 1):

- Emotions and feelings perceived by students as having a potentially negative impact on self or on the encounter
- Professional behavior affected by emotions, consisting of self-reflected concerns regarding “unprofessional” management of the encounter as a result of emotions (intrinsic or evoked by patient’s response)
- Professional behavior affected by nonemotional issues, consisting of self-reflected concerns regarding “unprofessional” management of the encounter because of inappropriate setting and/or inadequate skills
- Long-term effects, which were concerns regarding the potential effects of these types of encounters on the student’s
Table 1
Classification of Students’ Self-Reflected Personal Difficulties and Barriers, Sackler School of Medicine, Tel Aviv University, 2004*

<table>
<thead>
<tr>
<th>Classification of issues that students found difficult to deal with</th>
<th>General description of internal and external factors that characterize the issues under each category in the left-hand column</th>
<th>Examples1 of specific personal difficulties (percentage6 of students who encountered each difficulty)</th>
</tr>
</thead>
</table>
| Emotions and feelings | Emotions and feelings considered to have a potentially negative impact on self or on the encounter | • Sadness (18.5%)  
• Anxiety from patients’ distrust (18.5%)  
• Guilt due to the student’s prior actions (11.1%)  
• Personal vulnerability/premonition—“What if this will happen to me?” (16.7%)  
• Helplessness due to the inability to cure (15.5%)  
• Emotions evoked by personal memories from a similar experience with illness in the past (11.1%) |
| Professional behavior affected by emotions | Self-reflected concerns regarding “unprofessional” management of the encounter as a result of emotions (intrinsic or evoked by patient’s response) | Communicator’s emotions:  
• Identification with (23.3%)  
• Resemblance to the patient (14.8%) that may result in impaired care and limited disclosure; or  
• No resemblance creating emotional disconnection (9.1%)  
• Fear of exhibiting a cold and distanced reaction (10.0%)  
• Fear of uncontrolled emotional outburst (i.e., crying—9.6%)  
• Self fear of breaking such difficult news (7.7%)  
Patient’s emotions:  
• Fear of inappropriate behavior in response to patient’s anger (17.8%)  
• Fear of being defensive due to patients’ mistrust of the system and the doctor (18.5%)  
• Concern with handling patient’s emotional outburst (13.9%) |
| Professional behavior affected by nonemotional issues | Self-reflected concerns regarding handling of the encounter because of inappropriate setting and/or inadequate skills | • Lack of sufficient familiarity with the illness and treatment options (13.9%)  
• Hesitancy regarding the amount and depth of information to be provided (10.2%) and extent of sharing of responsibility for this decision (4.6%)  
• Inadequate familiarity with patient (9.3%)  
• Personal difficulty with providing the difficult information without the ability to soften the blow (7.4%)  
• The fact that patient’s husband is a lawyer (6.5%)  
• A low level of professional self-efficacy (4.3%)  
• Finding the time and availability to break the news (5.6%)  
• Having to call the patient to schedule a BBN encounter (1.9%)  
• Diagnosis made by a colleague (0.9%) |
| Long-term effects | Concerns regarding potential future effects of these types of encounters on professional behavior or personal lives | • Fear of burnout (2.8%)  
• Fear of possible medical misjudgment and errors (4.5%)  
• Deterioration in personal and professional confidence (4.3%)  
• Feeling of failure (1.9%) |

(Continues)

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Future professional behavior or personal life  
• General dilemmas, difficulties, fundamental issues and debates (ethical and others)

Table 1 describes the different categories and examples of the types of problems in this category.

The types of communicators  
From our analysis of the students’ disclosures, we identified the following four different types of communicators, each of which encompasses a set of elements: the distanced (detached), the defensive (avoidant), the hesitantly courteous, and the wholeheartedly involved (empathic). In the following paragraphs, we will briefly describe each type and provide an example of the pattern of communication, the personal difficulties each type of communicator identifies, and each type’s level of SA. Table 2 summarizes the way each of the SPIKES protocol components is practiced by each type.

The distanced (detached): five men and ten women. This is a communicator who maintains an emotional distance from the patient, manifested by concern that one might identify “too much” with the patient with a subsequent negative impact on one’s own role as a professional, and a fear of being “swept away.” The solution is to distance oneself from the patient and the patient’s suffering and to detach one’s own feelings and emotions.

The distanced communicator tends to objectify his or her role as news bearer and focuses on the need to tell the “truth.” He skips the Perception and Invitation parts of the SPIKES protocol and determines on his own the amount and content of information provided. Ignoring what the patient thinks usually stems from the communicator’s belief that he or she knows what the patient wants and needs to know. The communicator assumes, for example, that the vignette-patient’s high level of intelligence and her suspicion of a tumor indicate a desire for the “whole truth.”

The distanced communicator focuses on the devastating effect of the news and on the life-altering situation that the news causes, as illustrated in the following quotes: “I need to tell her that...”
The totals of the percentages exceed 100% because most students mentioned more than one difficulty.

This table is based on an analysis of personal difficulties and barriers that 103 sixth-year (i.e., senior) medical students stated they experienced when asked how they would deliver bad news to a patient described in a challenging vignette. The students were asked to reflect on the difficulties and barriers they felt they would experience concerning this case of delivering bad news. The authors found that these perceived barriers and the ability to reflect on them influenced the manner and content of the communication during the envisioned written encounter.

The six classifications contain examples of only the main difficulties recorded by the students.

The totals of the percentages exceed 100% because most students mentioned more than one difficulty.

### Table 1 (Continued)

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<th>Classification of issues that students found difficult to deal with</th>
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<th>Examples* of specific personal difficulties (percentage* of students who encountered each difficulty)</th>
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<tr>
<td>Dilemmas, difficulties, and fundamental issues</td>
<td>Fundamental issues (ethical and others)</td>
<td>● A general statement regarding the difficulty in dealing with communicating such bad news (25.2%) to a young woman with young children (22.2%) ● The ethical dilemma related to a request for euthanasia (11.1%) ● Difficulty in accepting death and dying (6.6%)</td>
</tr>
</tbody>
</table>

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**The defensive (avoidance): Seven men and seven women.** This type of communicator is trapped (enmeshed) in his or her own concerns and fears, is thus unable to “see” the patient, and avoids being the primary health care provider for the patient. The encounters, as described by this type of communicator, seem very technical and abrupt. The news bearer provides limited information and emotional support and avoids expressing...

As a young woman, an independent mother of a child, I have a horrible feeling about breaking such bad news to another woman—What is the right thing to say? How do you deal with such news? I had great difficulty handling the way I will break the news question (second question), and I feel I needed more time and personal emotional work with myself to handle this situation. . . . I identify with her too much, and that is why I had difficulty coping with this. I still believe that my personal skills as a compassionate and understanding person will help me through these situations.

A high level of awareness of her own difficulty did not seem to resolve the barrier, as this student delivered the news by providing only technical information, avoiding the need to address her emotions or those of the patient. The high level of identification creates a feeling of overwhelming emotions that leads to a coping mechanism of detachment. The “distanced” type of communicator usually either skips or chooses to deal very briefly with the Emotions and Empathy (E) component of SPIKES. This type of communicator’s fear of identification with the patient impairs the communicator’s ability to identify specific emotions and leads to the only place that will enable the news bearer to function—being emotionally detached from the patient.

Although looking into possible gender differences is beyond the scope of this paper, one noteworthy interesting observation is that all the women students who identified themselves as being mothers were found to belong to our distanced type of communicator. A possible explanation for this may be the powerful experience of feeling overwhelmed by the fear that this may happen to oneself (vulnerability); such a fear may have interfered with these mothers’ ability to create meaningful relationships with the patient in the vignette.

In the encounter as envisioned by the student, he focused on providing the patient with all the professional knowledge (he believed) she needed. He rarely discussed his or the patient’s
The information about the communicators is from a qualitative analysis of the responses from 55 of the 103 sixth-year (senior) medical students who were asked to visualize their interaction with a patient in communicating bad news after reading a challenging vignette. The table describes the way each of the four types of communicators (identified from the responses) said they would communicate bad news and relates the communication types to the application of the six SPIKES protocol steps. (SPIKES is a protocol for the delivery of bad news).

<table>
<thead>
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<th>SPIKES step and its application by communicator</th>
<th>Type of communicator and main concern/difficulty of each type that emerged from students’ self-reflection</th>
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<tbody>
<tr>
<td><strong>Setting</strong></td>
<td><strong>Distanted:</strong> Feels overwhelmed and incapable to deal with self and other’s emotions</td>
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<tr>
<td></td>
<td>Focuses on collecting missing medical data. Usually pays little attention to the physical environment</td>
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<tr>
<td><strong>Perception</strong></td>
<td>Tends to skip</td>
</tr>
<tr>
<td><strong>Invitation</strong></td>
<td>Tends to skip</td>
</tr>
<tr>
<td><strong>Knowledge</strong></td>
<td>Decides on his or her own how much information to provide. Focuses on “truthful,” lengthy, detailed disclosure</td>
</tr>
<tr>
<td><strong>Emotions and empathy</strong></td>
<td>Avoids referring to patients’ emotions or expressing empathy or self emotions</td>
</tr>
<tr>
<td><strong>Summary and strategy</strong></td>
<td>Repeats information and makes plans for treatment by self. Explicitly takes responsibility for future communication and meetings that will focus on patients’ additional questions. Reassures the patient for “being there for him or her,” but avoids addressing the emotional impact of the news</td>
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A willingness to “be there” for the patient. The way the encounter is conducted arouses the feeling that this is a strenuous situation for the news bearer, who mostly wishes to “get this unpleasant episode over with.”

Like the distanced type, the defensive type also determines what amount of information the patient should receive and the pace of its disclosure. However, skipping the Perception (P) part of the SPIKES protocol does not reflect a belief in “knowing” patient’s needs but merely a dismissing of a part of the conversation that seems not important. This communicator seems to decide what to say according to his or her own level of comfort with the information. Information given is mostly kept to the minimal necessary amount as perceived by the student. “Honesty” is used here not as a principal, as it is by the detached type, but more as a protective measure.

Student #45, female, describes a brief and technical encounter with the vignette-patient that she began with no warning shot: “MRI results are not good. The medical examination shows that there is a tumor.” The news is ‘dropped’ on the patient, skipping the patient’s Perception or obtaining an Invitation for the amount of information the patient wants to get.” She continued,

As seen in the above quotation, the content, depth, and boundaries of the disclosure were dictated paternalistically by the student. Does this strategy obscure the discloser’s professional attitudes and personal difficulties? When asked to reflect on her difficulties experienced in this case, the student wrote,
Stress and anxiety, because I almost did not send her to the MRI, feeling of professional doubt.

Personal identification: The patient’s age, family and career situation are similar to mine.

Helplessness: I cannot help her medically. I cannot save her life! I have no idea how to deal with this.

These powerful emotions may have undermined her ability to connect with the patient and provide her with empathic compassionate care. The communicator was trapped in her own concerns (professional doubt, fear for self, and helplessness) that prevented her from being attentive to the patient’s needs and expressing compassion. Choosing to primarily present the perceived professional failure as a barrier might explain why this student delivered the news in a defensive manner. Despite presenting other concerns that could make her choose to be detached, the threat to her professional self seems to be dominant.

The defensive type of communicator seems to be anxious while anticipating a specific patient’s reaction to the bad news. Mostly, the emotional discomfort with this situation reflects concerns due to one’s earlier actions, (such as nearly missing the diagnosis); fear of eliciting sorrow; or fear of possible outcome of the encounter, such as a concern of being sued by the patient’s husband, who is a lawyer. This type chooses not to detach emotionally but to run away from the situation, to keep the level of involvement to a minimum if at all, because of the personal concerns he or she experiences. For example, Student #28, female, was trying to end the conversation as quickly as possible by providing minimum information. She writes, “If she will ask for much more information and ask many questions, I will provide her only with the minimal necessary information, and promise to answer her questions in the future when I learn more, or advise her to ask an expert.” She made no effort to establish a relationship with the patient. She suggested the family as a source of support: “You are not alone, you have a husband and two older kids that will support you.” Throughout the encounter there was no suggestion that she, the physician, was someone the patient could lean on.

Her avoidance behavior might be explained by her own reflection on the barriers within herself:

Guilt and emotional discomfort. The patient is angry at me and at the system because of her mother’s suffering while under my care. Consequently, I might feel vulnerable and in need of protection because of guilt feelings that may prevent me from providing Yael with the confidence she needs in order to establish trust in her physician.

My acquaintance with the family members may evoke identification emotions and pity that will prevent me from giving the news candidly. I might try to avoid giving the full news, be ambiguous. I need time to work on my emotions to figure out what I need to tell.

Her husband is a lawyer, and this might scare physicians and might prevent me from giving her the right treatment; I may want to transfer the responsibility to others to avoid litigation. I need to document everything and be transparent in all decisions.

This student, despite exhibiting impressive self-awareness of her own difficulties with the situation and of their possible influences on her ability to communicate during the encounter, chose the avoidant approach while delivering the news. The information she gave was ambiguous, and she referred the patient to other specialists for every question raised by the patient. This might reflect overprotectiveness toward herself. Again, of interest is that despite mentioning identification as one of the possible barriers, this is expressed only second to a more overwhelmingly identified issue: guilt and anticipation of responses of anger from the patient.

In our study, communicators who were threatened by specific multiple issues rather than by the general “identification” threat chose mainly to defend themselves by distancing and detaching emotionally.

The hesitantly courteous: Three men and eight women. This type of communicator handles the conversation in a step-by-step manner, focused on the patient’s needs. The communicator pays major attention to the setting by preparing the time and space for the conversation. He or she assesses the patient’s perceptions and is attuned to the patient’s needs, but is not attuned to his or her own needs. The students of this type followed the SPIKES protocol guidelines meticulously, concentrating on the best interests of the patient. However, although they tailored the conversation to the patient’s needs, they limited their own emotional involvement with her because of concerns regarding its toll on their own professional and personal lives.

Asked to self-reflect, the primary fear that students who were this type of communicator expressed was that emotional involvement with one patient may be perceived as unprofessional behavior because it might decrease the ability to provide good care to their other patients. Student #56, female, wrote of her concern at “being drawn into the situation, due to the impact of the negative emotions on her professional expected behavior, such as taking other patients’ time.”

The second fear is the potential negative influence of such involvement on the physician’s personal life. As a result of these fears, the communicator is hesitant regarding the level of personal and professional involvement. The news bearer deliberately constructs strict boundaries between himself or herself and the patient, allowing the fear to prevent the news bearer from expressing his or her emotions, connectedness, and needs in the encounter. Student #70, female, wrote explicitly that “in order to deal with this tragic case I will try to create an emotional distance and move forward in my life. Not to let the sorrow control me.”

Another example of this type is Student #60, male, who provides information in a timely manner. He is patient-centered, assesses the patient’s informational and emotional needs, and conveys understanding for her situation. However, his description of the occurrences in the encounter lacks expressions of connection with the patient. In his writing he moves between discussing the specific patient characteristics (e.g., that she is a mother of three) and referring to “patient’s needs” in general. He also vacillates from the use of the singular and plural as he writes at times “I understand you” but at other times writes “we (physicians) need to ask patients if they have any further questions.” Many of his phrases are based on what should be done, especially when it comes to the expression of
difficulties he experienced with the necessarily for himself. He believes he is doing the motivation underlying it. This type of itself but also by the way it is done and number and accessibility off-hours) is authenticity of an action (such as connecting and helping the patient. The personal phone number is a way of that they felt that providing their stated by other types of communicators dealing with the same issue, who wrote their exam responses, students who expressing by shifting constantly between what he is doing and what he thinks needs to be done. He wants to follow the “rules” and is explaining that to the reader (of the exam), but apparently knowledge is not enough when it comes to the part of the encounter involving the E (Emotions) component of SPIKES. The courteous communicator hesitates concerning the level of involvement a professional should have with his patients. He realizes intellectually that there is a need to convey understanding and empathy, but he does not necessarily feel it.

This type of news bearer is taking the “right” actions, but there seems to be no personal commitment toward the patient. This student (#60) wrote that he would give his personal cellular phone number to the patient, but he immediately added, “I will explain to her that she can use this only in emergencies.” Giving the personal phone number is done as part of a perceived “right” behavior, to overcome the patient’s disbelief in the physician and the medical system. This is explained in his reflection on his difficulties (responding to exam instruction #3): “... fear of the patient’s disappointment and subsequent distrust—I can resolve this through being available to her (providing my cellular number), but be careful to tell her to limit calls to emergency situations so as not to interfere with my private life.” This phrasing differs from that stated by other types of communicators dealing with the same issue, who wrote that they felt that providing their personal phone number is a way of connecting and helping the patient. The authenticity of an action (such as providing a private cellular phone number and accessibility off-hours) is measured not only by doing the action itself but also by the way it is done and the motivation underlying it. This type of communicator constantly debates with unresolved issues of boundaries and self-alienation. He believes he is doing the “right” thing for the patient but not necessarily for himself.

This student refers to three personal difficulties he experienced with the encounter. Of interest is his choice to use the word “fear” describing each one of them: The first, “fear of patient’s disappointment and distrust”; second, “fear of disappointing the patient—I’ll try to get the best available information and split my time well between her, my other patients and my personal life. This will not be easy”; and third: “I am afraid of not being able to create a clear split between my professional and personal life.”

The three worries are all dealing with potentially negative impacts on the student’s personal life and on his time to care for other patients. This seems to lead to a conflict, in which the professional self tries to build relationships but the fear of inflicting damage on one’s personal life prevents it. The hesitantly courteous communicator wants to be perceived as a “good physician.” He tries very much to do the “right things” and be considerate. He really cares for the patient; however, his behavior might phenotypically look detached or avoidant at times. There are no guilt feelings, but the prime concern is not to “disappoint.”

The wholeheartedly involved (empathic carer): Nine men and six women. The wholeheartedly involved communicator is fully present in the encounter, focused on the patient’s needs as well as his or her own personal and professional limitations. During the encounter, this type of communicator is not skipping components of the SPIKES protocol, and he or she usually includes a few sentences to describe self-preparation for the encounter. After learning the patient’s perception and receiving an invitation, he or she gradually provides the news while at the same time addressing the emotions expressed by the patient. This carer shares thoughts and a suggested plan with the patient and expresses empathy. In their exam responses, students who were this type of communicator explained their intention to convey their emotions when they feel them, when appropriate. They mention different ways of dealing with the patient’s emotions, including touch and showing compassion.

Responses to the personal difficulties question show that this type of communicator is aware of experiencing several different explicit types of difficulties. This news bearer expresses emotions, personal experiences, and fears clearly and describes various ways of resolving them, as illustrated in the following quote by Student #33, male:

I shouldn’t repress my emotions, I need to express them, and even if I want to cry I should cry (in a controllable manner). I need to remember, however, that the patient is the focus. I also need to spend time with my family and enjoy life. I need to find a place/a support group within which to express my own emotions and thoughts.

This type of communicator attends to the patient’s needs openly, courageously, and with compassion. He or she is able to exhibit conscious presence and preconsider a variety of potential emotional responses. The wholeheartedly involved communicator is able to consider the patient’s diverse needs, avoid making decisions for the patient, be flexible, and mutually choose a path that will address both parties’ needs. Consider this comment by Student #64, female:

If she [the patient] will express anger, I will need to provide empathy; if she will express accusations towards me, I will suggest getting a second opinion; if she will express sadness, I will express understanding.

This approach differs from that of the other types of communicators, who mentioned dealing with all expressed emotions in a uniform manner—mostly by being silent. In contrast, Student #64’s comment above shows that she is not afraid of patients’ reactions but that, rather, she is well prepared to harness her emotions in the service of the patient.

The following comment is from a wholehearted communicator (Student #61, male), who expresses his own fears of death and dying and is able to see the patient as a person in need of his compassionate help. During the envisioned encounter he expresses a high level of empathy, listens carefully to the patient, and provides information gradually. He is able to map the complex challenges of the situation and to reflect deeply on his own difficulties in handling the case:

For me this is one of the most difficult subjects in medicine. My first feeling is one of failure. My traditional role as it has been presented to me in my training is to “cure” patients, and here I discover that I cannot change the course of things. Moreover—I know that the patient will suffer and I will not be able to effectively...
alleviate her suffering. Just knowing this patient and her family’s tragic destiny is very painful for me. These kinds of stories evoke within me strong feelings of pain and empathy. They even make me, at least for a short while to fear for myself or for my loved ones. The fact that the patient has three little children is particularly painful. Another disturbing feeling is the information I have. It is very difficult to decide what to tell and what not to tell . . . where is the limit beyond which excessive information will harm the patient?. . . From the legal perspective it is easy, however making the right moral decision is complicated. . . . How can I help the patient to choose the path of coping that will be the best for her—for her and not for me? I personally would have chosen not to know whether this might be a noncurable situation and how much time I still have to live. But maybe this patient does want to get the information. . . . I feel that these conditions are highly charged emotionally and handling them cannot be learned from books.

It seems that my way of coping is to focus on the positive sides of this profession. . . . I also believe that even if I cannot cure a patient, I can still help her and her family for the rest of life she has left. . . . Knowing this gives me a lot of strength and motivation.

This example illustrates how a vignette, even in the setting of a test, can elicit an intense and profound emotional involvement and stimulate examinees to react as they would to a real-life situation. This type of communicator is highly self-aware and capable to reflect on his or her own feelings and inner debates. Reflecting on a wide range of concerns (fear, suffering, and moral issues) elicits remarkable humility. In responding to the vignette, these communicators constantly fluctuated between their own dilemmas as physicians and human beings and the needs of their patient and her family. As illustrated by the comments above, they deal maturely with fundamental questions regarding the limitations governing both medicine and the physicians who practice it. By acknowledging the limitations, these communicators move in the direction of finding solutions that they can live with. They come into the encounter after having faced both their own and their patient’s issues within themselves. Their strength and motivation to help enables them to exhibit a high degree of empathic skills and ability to be fully engaged and involved with the patient.

Of interest is our observation that this type of communicator chooses to express feelings (e.g., pain) when asked to reflect on difficulties; however, they do not perceive those feelings as having potential negative effects. The themes they choose to point out as dilemmas and barriers are mostly embedded in the general realm of ethics and the communicator’s world view.

Discussion
This study is, to the best of our knowledge, the first that systematically examines the actual influence of barriers and difficulties within the discloser’s own way on the way the bad news encounter is handled. The relationship between the personal difficulties and type of discloser/communication pattern revealed in our students’ responses to the exam suggests that the ability of medical students (and, potentially, physicians) to communicate effectively with patients may be enhanced if they learn to address their personal and professional difficulties, enhance their SA, and obtain help in dealing with those difficulties. Therefore, if our findings are, on the whole, generalizable—as we believe that further research will show—they have significant implications for both educators and practitioners that we address later in this article.

The four communicator types we identified in this study are actually located on a continuum, with some merging points, and are broadly concordant with the well-known care paradigms physician-centered care, patient-centered care, and relationship-centered care (see Figure 1). As illustrated in the figure and discussed below, the distanced and defensive types are mostly “physician-centered,” the hesitantly courteous are “patient-centered,” and the wholeheartedly involved are “relationship-centered.”

The first two types of communicators (distanced and defensive) are for the most part physician-centered. These communicators try to take complete control over the situation, believing they know what the patient needs. They assume that such control will enable them to handle the encounter “professionally” (for the distanced type) and “safely” (for the defensive type). They are the sole decision makers regarding how much, when, and how to provide necessary information. The distanced communicators are most concerned with maintaining their professional identity, which, they fear, might be threatened by connecting emotionally with the patient. This type of communicator provides a wealth of “objective” information about the disease, as facts and as messages that “need” to get through. The defensive type is mostly concerned with perceived threats of the interaction on his or her personal and professional self. This leads this news bearer to limit the interaction...
and the amount and content of information he or she provides, even if the patient explicitly requests more. Both types, for different reasons, avoid expressing emotional connection to either self or the patient.

The greatest risk these types experience is either self or the patient expressing emotional connection to types, for different reasons, avoid the patient explicitly requests more. Both information he or she provides, even if and the amount and content of attentiveness to the verbal and complexity of emotionally charged patients' needs as well as their own. The communicators of this type grasp the nonverbal expression of the needs of the person receiving the news and to their own emotional needs.

We found that there is a major difference among the various types of communicators with regard to their ability to self-reflect and deal with their personal and professional barriers. This ability may reflect different levels of personal mindfulness rather than differences between the types of difficulties that they actually experience. Hence, the problem is one of comprehension and interpretation (e.g., threatening versus manageable, conscious versus unconscious) and consequent coping ability.

Heightened SA of one's own difficulties and limitations and the allocation of time to deal effectively with them can potentially increase the likelihood of achieving a more empathic and tailored interaction between physicians and patients. This is concordant with earlier findings indicating that promotion of SA and reflection is an important tool for upgrading communication skills1,18,33 and improving professionals' comfort and security in their missions. In this study we found that self-reflection ability actually affects various components of the encounter, including the chosen focus-of-care paradigm, the amount of information given, the words used to deliver information, compatibility with patients' needs, and handling of emotions (the communicator's own emotions and those of their patients). The communicators who are less able to reflect on their own barriers tend to set more rigid boundaries within the relationship in contrast to the relative flexibility of those with a greater degree of SA, even in the face of concerns regarding privacy or burnout.

Earlier studies have shown that inadequate attention by physicians to their own emotions may ultimately result in compromised patient care18–22,24,34 by arousing false hopes and expectations, providing premature reassurance or prescribing unnecessary therapies. Our findings support this by demonstrating how communicators who are unable to elicit their own difficulties and barriers fail to be attentive to patients' emotional responses during the encounter; they tend to skip the E (emotions and empathy) component of the SPIKES protocol and fail to connect to the patient's or their own needs.

Can inappropriate communication patterns be modified in a positive sense by enhancing physicians' ability to recognize the barriers that exist within themselves? Although at least one study indicates that this can be done,3 we feel that this is just one (important) component of the solution. For example, some students in our study were able to self-reflect on their difficulties yet failed to overcome those same difficulties when visualizing different scenarios in the encounter. Specifically, those students reflected on their concern that their high levels of identification with the patient would lead them to avoid providing truthful information regarding the situation. Yet in their encounters they repeatedly mentioned avoiding providing the information even when they were explicitly asked to do so by the patient. This implies that developing SA as a skill is necessary and important but not sufficient. We need to further evaluate the ability to deal with the observed individual barriers and the mechanisms that may enhance people's abilities to overcome those barriers.

Previous reviews have speculated that a primary weakness in the process of delivering bad news is related to the preparation before the encounter. It has therefore been suggested that advanced guidance in cognitive and behavioral methods for dealing with the communicator's emotional discomfort should become an integral part of the training process of health professionals toward upgrading their capabilities in the delivery of bad news.14,15 The purpose of reflection is not only to conduct a retrospective cognitive analysis of the encounter and the experience but also to seek to identify and anticipate potential difficulties and work on a strategy to deal with them. A good example might be the prevalence in our study of the "distanced" type of communication among students who were mothers. This might reflect how a specific difficulty with a specific case might benefit from addressing and resolving the difficulty before the actual encounter. Toward this end, we have developed a suggested working tool (the Preparatory SPIKES) to promote reflection and SA as a preparation for each specific encounter toward the objective of accomplishing...
List 1

The Preparatory SPIKES—The Main Questions, Based on the SPIKES Protocol Acronym—That a Practitioner Should Ask Him- or Herself to Enhance Self-Awareness to Personal Difficulties When Preparing to Deliver Bad News to a Patient

- S—SETTING. How do I prepare myself and my environment? What do I need in my environment in order to make me feel more comfortable? For example, do I need a table between me and my patients? Do I feel more comfortable facing the window or the door? Do I prefer (or reject) another professional’s presence while I deliver the news? Do I feel more comfortable wearing the white coat, etc?
- P—PERCEPTION. What is my perception of the encounter I will be conducting? What is my perception of the patient and his/her family, the illness, and the prognosis? How threatened am I by this illness/meeting/patient/case?
- I—INVITATION. What are my inclinations about providing information and why? What am I willing to tell/talk about? What do I fear saying? What would I want to “know” if I were the patient?
- K—KNOWLEDGE. What is the depth of my current knowledge regarding the illness I am about to discuss? What additional knowledge do I need to gain to manage the encounter? What other information do I need about the patient or family? About other services that this patient might need?
- E—EMOTIONS AND EMPATHY. What do I feel? What might be the emotional impact of this case/patient/illness on me? How well can I identify with (place myself in the shoes of) the patient? What are my feelings toward this patient and/or his or her family? Do I have feelings that might interfere with handling this encounter? How can I deal with them?
- S—SUMMARY, STRATEGY, and SUPPORT. In view of all of the above questions, what other steps should I take to cope better with the task? What type of approach am I going to take? Whom should I turn to for support before or after the encounter? What do I need to settle within myself, and how?

* This list presents a suggested working tool developed by the authors to help enhance students’ and physicians’ self-awareness of their own difficulties and other issues before delivering bad news to a patient. In this working tool they used the acronym of the SPIKES protocol for delivering bad news, adapted and refined to focus on the preparation of the news bearer prior to the BBN encounter. The tool was developed based on the present study’s findings that empirically demonstrated that personal difficulties and barriers influence the news bearer’s pattern of communication when delivering bad news.

† This term, “SUPPORT,” does not appear in the original SPIKES protocol but has been added by the authors to emphasize the critical importance of adequate preparation, including turning to others for support.

Conclusions

Our findings have emphasized the powerful influence of personal difficulties and barriers within the news bearer on his or her communication pattern. The findings highlight the importance of learning to identify these difficulties because they can greatly affect the content and manner of the news bearer’s communication in an encounter with a patient. Identification of these difficulties/barriers is an important first step that should be followed by efforts to resolve them before the actual encounter. This resolution must start with SA and hopefully can be achieved by the individual with the help of others and strategies such as the structured protocol suggested above. That protocol provides a potential tool for the BBN deliverer, enabling that individual to focus on self issues that might affect his or her handling of the encounter to come.

Practicing this protocol can become a part of the in-depth, continuous process of learning to identify one’s own barriers to and difficulties in facing the delicate everyday tasks of caring for the sick and using various support systems such as Balint support groups, experiential discussions,15,35 narrative writing,36,37 and experiential mind—body skill sessions38 that encourage mindfulness and reflective approaches.39,40

Limitations

Although this study provides new and important empirical data, it has some limitations. First, it is based on a vignette and written answers rather than real-life interactions between professionals and patients. Yet, from direct feedback from students, who expressed a feeling of being emotionally affected by the vignette, and the findings of other studies,41,42 it is known that the discrepancy between findings from vignette studies and those from real-life experiences may be a matter of degree (less intensity) rather than being nonrepresentative of real-life encounters.

A second limitation is that our results are based on exam answers, and trainees might speculate what is expected from them in order to receive a higher score.43 Furthermore, two persons can write the same sentence but express it very differently with nonverbal communication messages, especially when they are not comfortable with the message expressed. These limitations call for the need to assess news bearers’ communication patterns in “real-life” situations. An additional approach that would allow generalizability would be to assess news bearers’ communication patterns identified in other institutions and countries, as our study obtained results from a single educational experience at one institution.

Future studies should further explore the role of gender regarding personal difficulties, SA, and communication patterns. In addition, it would be instructive to compare the personal difficulties experienced by the same physicians when exposed to different vignettes. This exploration should focus on which difficulties are persistent across cases and which differ, and it should seek to understand how these difficulties affect physicians’ patterns of communication.

Recommendations

The findings of the present study have major practical implications. First, they underscore the complexity of diagnosis–disclosure interactions, especially those involving bad news, by illustrating the breadth and variety of difficulties that arise from this communication task. Second, they empirically demonstrate the
relationship between the news bearer’s personal difficulties and the type and quality of his or her communication in a diagnosis–disclosure encounter with a patient. This emphasizes the importance of helping students and physicians identify, understand, and cope with their emotional difficulties as a crucial step toward more effective patient care and professional well-being.

Our findings also indicate that enhancement of SA in itself is not enough, and additional support options and systems should become available to help the professional resolve and cope with these difficulties in a positive manner. This part of the recommendation is embedded in the last stage of the working tool (strategy and support), which leads the individual and his or her mentor (supervisor) to prepare a plan before the actual encounter with the patient. Identifying the issues, understanding them, and resolving them seem to be essential initial steps toward establishing a relationship-centered care communication model that will best suit the patient and the physician.

From an educational point of view, focusing on these difficulties will achieve what Wear and Varley recommend, which is providing students with learning experiences that encourage them “towards deeper, richer considerations of what their patients are experiencing and what trainees themselves are experiencing in that relationship.” We believe that the Preparatory SPIKES working tool suggested in our study will encourage such in-depth exploration of self and others.

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