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Teaching midwife students how to break bad news using the cinema: An Italian qualitative study

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ABSTRACT

Delivering bad news is a difficult task that involves all healthcare professionals, including midwives. The hypothesis is that, in order to learn how to disclose and to discuss bad news, students need a phase of personal reflection, of awareness of their own emotional processes. The use of films in healthcare education can foster this process evoking different emotions concerning suffering and disease, in a "safety zone". This study examines the effects that a course, which uses reflection as a method of learning and the cinema as a teaching tool, produces on a little group of Italian third-year Midwifery students. From the content analysis (supported by Atlas-Ti® software) of the texts produced by the students after the vision of two entire films, it appears that they correctly identified many elements related to good and poor communication of bad news and that they were able to describe the emotions felt while watching the film, but still revealed a certain difficulty to interpret them. The course helped students to recognize the value of reflection on their emotions to better understand others, to empathize with people who suffer, but also to recognize their difficulties and compete with their own limits.

Introduction

The role of midwives in communicating bad news to patients and relatives is important because, being in daily close contact, they may understand how women deal with their condition, know their concerns and desires. Midwives may be more aware of how women adapt to what they are told and may monitor the patients' realization of their condition (Dewar, 2000; Lalor et al., 2007; Warnock et al., 2010).

Background

Breaking bad news

Any information that produces a negative alteration to a person's expectations concerning the present and future could be deemed bad news (Buckman, 1984). Bad news does, of course, have gradations which, to a certain extent, are subjective, dependent on an individual's life experiences, personality, spiritual beliefs, philosophical standpoint, perceived social supports, and emotional hardiness (Fallowfield and Jenkins, 2004). The expression 'breaking bad news' is usually associated with the moment in which negative medical information is communicated to patients and/or their relatives.

During last thirty years many changes have occurred in the healthcare world, the concept of bad news has changed and the communication function is no longer limited to the physician. "*Breaking bad news*, writes Tiernan (2003) *is not just about communicating about diagnosis or recurrence, imparting correct information, discussing the transition from active therapy to palliative care; it is not just about the correct words to use; it is not even just about listening. Communication is about all of these things, but it is about much more. Communication is about the relationship we establish and build with our patients.*"

Delivering bad news is a difficult and stressful experience that takes place before, during and after bad news is broken (Arber and Gallangher, 2003; Rosenzweig et al., 2008). Discomfort with disclosing bad news may be due to many factors: lack of training, fear of patients' emotional reactions, fear of being blamed for the bad news, fear of one's own emotional reactions, fear of the

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patients' suffering and death, personal fear of illness and death, and uncertainty associated with not being able to provide answers (Buckman, 1984). Institutional barriers such as inadequate amounts of time or not having adequate support from other members of the hospital institution are also reported (Dosanjh et al., 2001). The reluctance to communicate bad news has been recognized for a long time. Rosen and Tesser (1970) coined the term, "MUM effect" for this tendency, *shown either by not transmitting the message at all, or by delegating the task to someone else*.

Moreover, in many reports of adverse obstetric incidents, it often emerged that, due to lack of communication, the woman, her partner and family felt that no-one had listened to them, causing litigation cases (Bick, 2010).

Teaching methods

Much has been written about the skills which are necessary for the effective delivery of bad news and consensus guidelines have been developed, for example SPIKES (Setting, Perception, Invitation or Information, Knowledge, Empathy, and Summarize or Strategize – Baile et al., 2000), ABCDE (Advance preparation, Build a therapeutic environment/relationship, Communicate well, Deal with patient and family reactions, Encourage and validate emotions – Rabow and McPhee, 1999) and others. The main negative aspect is that guidelines and protocols do not adequately account for the individual's interpretation of the significance or impact of the news. Moreover, although the various guidelines offer practical suggestions, they do not address the emotional aspects of the problem. Before providing students with instructions on how to behave, as sustained by Arber and Gallanger (2003) and Sandars (2009), we believe a phase of personal reflection, of awareness of their own emotional processes is fundamental, because what affects people's lives cannot simply be translated into a list of actions, but must result from the understanding of the complexity of all the elements, the feelings, and the emotions both of the operators and of the patients and their families.

Most of the studies in literature use standardized patients to teach how to disclose bad news, but they are very expensive in terms of cost and time (Fallowfield et al., 2003). Furthermore, some authors argue that this pedagogical approach may encourage students to become "simulation doctors" who act out a good relationship to their patients but have no authentic connection with them. They also point out that studying human experience in literature and art enables students to better understand their own experiences and this ultimately helps them improve their ability to relate to patients (Hanna and Fins, 2006).

In the same line, in their review Satterfield and Hughes (2007) report that a growing body of literature suggests that attending to emotion and communication skills in medical providers might beneficially impact both patient and provider. Ambuel (2003) highlights the need to reduce learners' discomfort in communicating bad news and Shapiro (2008) affirms that reflective practices and incorporation of medical humanities can help students achieve goals, such as coping with difficult emotions, specifically fear, anxiety, and the desire to distance oneself from decline and death.

The main value of reflection is to develop an understanding of both the self and the situation. In order to develop a therapeutic relationship, fundamental when discussing bad news with patients, it may be useful to bring out awareness of strong feelings, recognize and understand personal beliefs and value systems of the people involved.

Although communication skills have a cognitive component, they should be taught to healthcare providers through an experiential and not just a didactic method (Rosenzweig et al., 2008). Breaking bad news requires advanced communication skills, which include interpersonal skills, nurturing reflection, conveying empathy and handling emotions (Rider, 2011).

Defined and shared solutions to the problem do not emerge in recent literature. Working in small groups, reflective questioning, role-play, note taking, group discussions, can help students become sensitive to the feelings of others and respond to future difficult encounters with patients who are experiencing profound suffering (Tiernan, 2003).

Students are often excluded from the communication of bad news in order to protect patients' intimacy (Harrison and Walling, 2010). Therefore, they have little authentic direct practice experience on which to reflect (Mann et al., 2009). Most of the courses on communication of bad news are addressed to resident or specialized doctors and very few are designed for undergraduate HCP students while no courses at all are envisaged for Midwifery degree courses.

Some theoretical articles can be found in literature on the use of reflection as a teaching method in midwifery courses (Phillips et al., 2002; Minter, 2005; Collington and Hunt, 2006), nurse courses (Scanlan et al., 2002; Wilding, 2008) and other HCP courses (Smith, 2011) as well as an exhaustive systematic review (Mann et al., 2009), while there are no articles on teaching communication skills applying the reflective method.

Cinema as a teaching tool

There is limited tradition of using films in healthcare education, but the experience is positive and has generated considerable enthusiasm for this tool. In their systematic review of cinema in medical education, Darbyshire and Baker (2011) affirm that "*The use of cinema in healthcare education has a theoretical basis*". A typical feature of a film is to allow the spectator to experience a different reality and it provides insight into the patients' history and helps understand their point of view. Films are used in healthcare education for their capacity to evoke different emotions and feelings concerning diseases in a zone of safety, they act as a mediator with reality avoiding students' direct involvement, their difficulties and anxieties (Shapiro and Rucker, 2004). The use of films can stimulate students' ability to reflect on their own mental activity and professional actions, putting them in contact with complex situations in protected contexts (Bergonzo et al., 2010; Blasco et al., 2011).

Although Alexander and colleagues (2005) explained in their guide how to use films in medical education for all the six areas of competence identified by ACGME in 1999, and the title of one paragraph was "Giving bad news", we can find only few other examples in literature (Alexander, 2002; Belling, 2006a, 2006b; Saab and Usta, 2006). Movies have been used in order to stimulate reflection (Blasco et al., 2010; Brett-MacLean et al., 2010; Blasco et al., 2011), and to teach ethics, palliative care, pain management, (Carpenter et al., 2008), professionalism, psychiatry and mental health (Hyde and Fife, 2005; Masters, 2005), nursing management (Stringfield, 1999). For more details see the systematic review conducted by Darbyshire and Baker in 2012.

The choice whether to show the entire movie or only some clips is determined by learning objectives and time constraints. By allowing time to view an entire movie, a shared experience is created, enhancing the potential for rich classroom discussion and learning.

Aim of the study

Verify whether a course which uses reflection as a method of learning and the cinema as a teaching tool can foster in students: