Assessment Task 5: My lesson plan for a simulation-based teaching session

Breaking bad news

Abstract

The lesson plan can be read without referral to the appendices, but the appendices will illuminate the flow of the whole workshop.

Word Count of Assessment: 2992
Word Count of Appendices: 2864

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Scenario: Breaking bad news

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Educational rationale

Bad news can be defined as "any information which adversely and seriously affects an individual's view of his or her future."[1] As such, while the SPIKES protocol was developed in the field of oncology, its use is wide ranging across most medical disciplines.[2] Breaking bad news is a complex communication skill but one which is inherently part of the medical profession. In the past, medical students learnt this skill through direct observation of clinicians while on clinical placement.[3] However, given the critical nature of this skill, more formal teaching is required to support medical students to deliver bad news in a way that minimises stress and the emotional burden to themselves and to the patients with who they interact.[3]

The goals of breaking bad news are[2]:

- Sensitive information gathering from the patient.
- Establishing the amount of information the patient wants and requires and delivering it in a supportive fashion.
- Minimise the emotional impact on the patient by using enhanced communication skills.
- Collaborate with the patient to form an acceptable treatment plan.

Learning Objectives

1. Describe the preparations needed for breaking bad news.
2. Discuss the barriers to the delivery of bad news.
3. Explore the strategies to facilitate the delivery of bad news.
4. Demonstrate the use of a recognised structured approach for delivering bad news.
5. Demonstrate advanced communication skills when breaking bad news.
6. Demonstrate the effective use of questions in patient-centred communication.

Learners

Fourth Year Medical Students in their final unit, **Preparation for Internship**.

This is a 6-week block which has 4 weeks on clinical placement and 2 weeks in block. The cohort of 240 students is divided into 3 groups which rotate into block. Each block has 80 students who either attend the morning (40) or the afternoon (40) breaking bad news workshop. The 40 students complete the workshop together and are divided into six groups for the simulation component. Faculty comprises of junior doctors who have been trained in simulation practices and have participated in other workshops such as conflict resolution.

Context of the simulation – learning activity (i.e. not an exam). There is formative feedback during the debrief and through completion of pre-workshop questionnaire, reflection, and workshop evaluation.

Teaching strategies

Guided Pre-Workshop Study

Students are expected to have revised the following three resources before the workshop:

- Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES—a six-step protocol for delivering bad news: application to the patient with cancer. Oncologist. 2000;5(4):302-311. http://dx.doi.org/10.1634/theoncologist.5-4-302 [2]
- Breaking Bad News Demonstration – OSCE Guide/Breast Cancer Diagnosis/UKMLA/CPSA. Geeky Medics. https://www.youtube.com/watch?v=MKnWkrPLGOs&t=28s [4]
- Communication Skills Module (revise module resources) (See Bennett and Lyons for an overview of module)[5].

Workshop Overview (3 hours 45 minutes):

1. **Welcome and introduction** to the workshop (15 minutes) (Make sure that the students are sitting in 6 groups)

Given the sensitive nature of the workshop, the first 15 minutes is critical to introducing psychological safety into the space. It is important to model the behaviours that will be conducive to the participants feeling psychologically safe in the space:

- Ensure that faculty are relaxed and welcoming as participants arrive. Make faculty introductions to the group.
- Give a thorough house keeping briefing regarding breaks, eating and drinking, break out rooms and toilet facilities. Clarity here also reduces stress.
- Students will have been briefed to wear their name badges but be ready to provide temporary name badges for those who may have forgotten theirs.
- Guide students to sit in 6 groups – having pre-prepared groups allotted to tables, reduces anxiety for those who may not be part of a larger group.
- Before introducing the running order and learning outcomes for the day, acknowledge the interpersonal risk-taking nature of the workshop. The participants may experience negative emotions, stress and anxiety and this may be a good moment to outline the supports available to students and staff through the university (pop links onto your PowerPoint slide).

2. Distribution of the **pre-workshop questionnaire** (see appendix 2) (15 minutes)

   Explain the relevance of each question and why it is being asked (self-assessment for students; improve the education for current and future students; understand the gaps in education; share the results of the training workshop – if ethics is in place).

3. **Review of Spikes** – A Six-Step Protocol for Delivering Bad News[2] (see appendix 3) (30 minutes)

4. Discussion (World Café Approach): **Barriers to breaking bad news** (see appendix 4) (45 minutes)

   Divide the group into 2 (use a breakout room and your simulation facilitators)

5. **Break** (15 minutes – 6 room set up can be done in this time if the simulation rooms were used for previous activities)
6. **Simulation** (1 hour 30 minutes)
7. **Session wrap-up** and evaluation (15 minutes)

Simulation Session

Preparation

Participants:

- **Medical student x 1** in the role of junior doctor
- **Medical student x 1** in role of chaperone (Clinic nurse – medical students have already participated in ward for a day with nursing students and have had immersive IPE)
- **Embedded faculty x 1** in role of Mr White, the patient.
- **Observer x 4** (Remaining medical students in group)
- **Facilitators x 2 (if possible)** (if 2 facilitators present: I to observe/support scenario, 1 to observe/support observers)

Equipment/location needed:

- Clinic room in outpatients (Corridor and clinic may be delineated by screens)
- Tissues, hand sanitiser
- Laptop for junior doctor to retrieve results (pin results to laptop monitor – appendix 5)
- Desk and three chairs (Initially the doctor's chair is facing the laptop and away from the patient
- Patient chart

Safety/risk:

All participants are aware that the session is centred around breaking bad news which implies that the scenario will involve disclosure of a negative clinical outcome. However, this needs to be explicitly acknowledged within the whole group. Therefore, in addition to the

usual briefing, the nature of the scenario diagnosis is reviewed with the embedded faculty in the role of Mr. White to ensure it is not a personally triggering scenario, and the scenario is noted for its clinical significance in the briefing. Participants are reminded of staff and student supports which are available i.e., EAP, student supports on LMS and also offered the opportunity for one-to-one debriefing.

Time duration:

- Briefing (15 minutes)
- Simulation (15 minutes)
- Debriefing (45 minutes)
- Reflection (15 minutes)

Case Summary:

<table>
<tr><td colspan="2">It is the afternoon outpatient urology clinic. Mr White is in an examination room. He has previously attended with fatigue, difficulty initiating urination and poor stream. He had been referred by his GP who also included the PSA results (4ng/ml)*.
He had a biopsy of his prostate 10 days previously and is awaiting the results.</td></tr>
<tr><td>Age</td><td>69</td></tr>
<tr><td>DOB</td><td>DOB: 12.11.1954</td></tr>
<tr><td>Past Medical History</td><td>Hypertension</td></tr>
<tr><td>Medications</td><td>Ramipril 10mg daily</td></tr>
<tr><td>Social history</td><td>Mr. White is married with three adult children. He retired from his plumbing business the previous year when his son took over. His wife is currently at work.</td></tr>
<tr><td>Biopsy results</td><td>Adenocarcinoma of the prostate, grade 3.**</td></tr>
<tr><td colspan="2">*PSA above 3ng/ml may indicate prostate cancer but there may be other causes for the raised level which the GP had explained to Mr. White.[6]
** The grade given to prostate cancer describes how aggressive the cancer cells are. This grading is known as the International Society of Urological Pathologists. Grading happens</td></tr>
</table>

at the time of diagnosis, using the prostate biopsy sample. It is assigned a grade from 1 to 5, with 5 the most aggressive on the ISUPS Grade Group system.[7]

Finishing cue: Mr White (embedded faculty) signals the end by thanking the doctor and standing up to leave.

Time out option: The junior doctor suggests they needs senior advice or the facilitators note distress or major clinical practice issues.

Briefing

The purpose of the briefing is to create a safe and supportive environment for our learners. This can be guided by Maslow's hierarchy as a framework for the simulation pre-brief. Do not rush the briefing – allow the participants to adjust to the simulation environment.

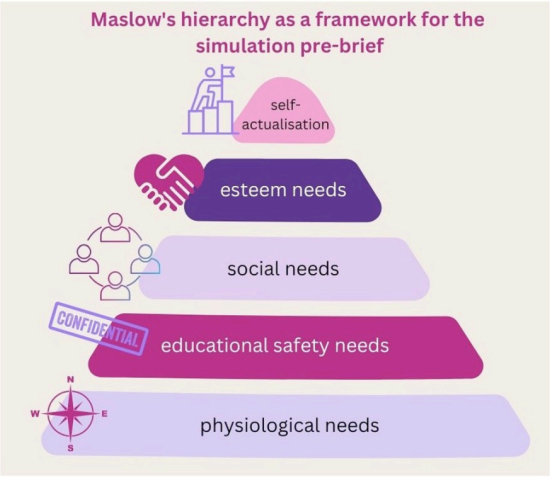

Image taken from Somerville et al, p. 1352.[8]

Steps to take during the briefing (these are points to cover but should be viewed as a prescriptive way of delivering the briefing. It is important to for the facilitator to be their authentic self):

- Introductions (faculty and medical students): it is important to welcome all participants positively into the session and create social connections through the use of names etc. Provide name labels if anyone has forgotten theirs.

- Confidentiality: This step is crucial to learner empowerment and engagement.
- Orientate to the objectives, session plan and simulation environment:

  Objectives of the Simulation:

  - Demonstrate the use of a recognised structured approach for delivering bad news.
  - Demonstrate advanced communication skills when breaking bad news.
  - Demonstrate the effective use of questions in patient-centred communication.

  Session plan and environment:

  - The physical space for the simulation and what props are in use.
  - Explain the role of embedded faculty and participants.
- Negotiate a fiction contract: The simulation environment is not real but we need learners to treat the scenario as authentic for an effective learning experience.
- Explain as much as possible: this lessens the inherent stress felt by many participants.
- Basic assumption: everyone is trying their best and this effort needs to be recognised.
- It is not an assessment but an opportunity to focus on learning where mistakes are normalised and treated as learning opportunities.
- Allow time for participants to ask questions.
- Explain the de-briefing process (If there are 2 facilitators organise the co-debriefing in advance).

Participant briefing (doctor breaking bad news)

It is the afternoon outpatient urology clinic. The clinic is extremely busy and the consultant has asked you to see some patients on your own. Mr White is in an examination room and is your next patient. You had scanned his notes at the start of the clinic. He has previously

attended with fatigue, difficulty initiating urination and poor stream. He had been referred by his GP who also included the PSA results (4ng/ml)*.

He had a biopsy of his prostate 10 days previously and is awaiting the results. The results show adenocarcinoma of the prostate, grade 3. The results are also available on the clinic computer in the examination room.

You need to enter the room and conduct the patient appointment and deliver the results to Mr. White following the SPIKES protocol. There is a clinic nurse (**Chris**) available.

Name	David White
Age	69
DOB	DOB: 12.11.1954
Past Medical History	Hypertension
Medications	Ramipril 10mg daily
Social history	Mr. White is married with three adult children. He retired from his plumbing business the previous year when his son took over. His wife is currently at work.
Biopsy results	Adenocarcinoma of the prostate, grade 3.**
PSA	4ng/ml*

*PSA above 3ng/ml may indicate prostate cancer but there may be other causes for the raised level which the GP had explained to Mr. White.[6]

** The grade given to prostate cancer describes how aggressive the cancer cells are. This grading is known as the International Society of Urological Pathologists. Grading happens at the time of diagnosis, using the prostate biopsy sample. It is assigned a grade from 1 to 5, with 5 the most aggressive on the ISUPS Grade Group system.[7]

Participant briefing (clinic nurse (**Chris**) – chaperone):

The participant in the role of clinic nurse is given the case summary and the following instructions:

The doctor may call you into the examination room. Your role is one of neutral support. You will reflect the actions of the participant (junior doctor breaking the bad news) and you will wait to be directed by them. You are initially standing by the desk and do not sit unless you are directed by the doctor. If Mr White becomes emotional, you may sit in the vacant chair and offer tissues. However, other than this point, wait to be directed by the doctor before you act (make tea, phone relatives etc)

Simulated Patient Briefing – Mr White

You will have received the following in preparation for the scenario:

- The SPIKES protocol.
- The SP observation sheet (See appendix 6).
- The scenario story board.

It is the afternoon outpatient urology clinic. You are in an examination room. You have previously attended with fatigue, difficulty initiating urination and poor stream. Your GP referred you because of your symptoms and also because your GP did a blood test related to your prostate and it was a little high. However, your GP said there were many reasons that it might have been high. The urology consultant did a biopsy of your prostate 10 days previously and you have come back in for the results. You are anxious but convinced that it will be ok. You came by yourself because you did not expect to receive bad news.	
Name	David White
Age	69
DOB	DOB: 12.11.1954
Past Medical History	A little bit of blood pressure, that is all
Medications	Just one blood pressure tablet, you take it at night.
Social history	You are married with three adult children. You retired you're your plumbing business last year when your son took over but you still

	have to help out and support him with managing it all. Your wife still works – she is younger than you and does not to give up work yet.
Learning Objectives of the Session	o Demonstrate the use of a recognised structured approach for delivering bad news. o Demonstrate advanced communication skills when breaking bad news. o Demonstrate the effective use of questions in patient-centred communication.

Following the story board, things that move the situation from low to high difficulty are:

- The environment was not adjusted for a conducive and empathic exchange.
- The doctor interrupts you when you are talking.
- The doctor gives a monologue without pausing to check your baseline knowledge and understanding, does not check that you want to hear the news or uses a lot of medical jargon.
- Poor communication technique e.g. limited eyes contact, arms folded, closed ended-questions, disregard for your emotional state.
- A lack of information about what will happen next (the doctor may defer to an oncology opinion and this is acceptable) and supports on offer.

As embedded faculty, it is your responsibility to end the scenario by thanking the doctor, "I have no further questions at the moment", if the doctor has reasonably attended to the breaking of bad news according to the SPIKEs protocol. It is also your responsibility to end the scenario if the participant shows any signs of distress or when all communication options have been exhausted.

Observer Briefing

The observers are given the case summary and also the Observer Feedback Sheet (appendix 6). They are advised to be prepared to take part in the debriefing which was mentioned in the general briefing and to consider the learning objectives of the session.[9]

Faculty Briefing

Faculty use the Observer Feedback Sheet (appendix 6). They use it to support their role in the debriefing phase. Faculty briefing (include additional notes depending on which group they are supporting). In addition, they will observe the participants and observers for any signs of distress which will indicate the need to stop the scenario.

Simulation Exercise

Storyboard (adapted from NHS diagram[10])

Debriefing

The debriefing phase will use the PEARLS approach (see appendix 7).[11] While it is expected the facilitators will be familiar with the approach the following table may guide the process.

	Objective	Suggested approach
1. Setting the Scene	Create a safe context for learning.	• Make a definite transition between the scenario and the debrief. • Set the scene by indicating how the debrief will run. • Remind the team that the SP and the observers will be included in the debrief
2. Reactions	Explore Feelings	• Begin with the junior doctor and include the entire team if they want to disclose their feelings.
3. Description	Clarify facts	• Make sure that it is a summary of the facts. • Does everyone agree with the description.
4. Analysis	Learner Self-assessment Focused Facilitation Provide information	• Ask learners what went well and what they would like to change. • State what you, as facilitator would like to talk about – based on what you observed and coming from a place of curiosity. • Close any knowledge gaps if required.
Any Outstanding Issues/Concerns?		
5. Application/summary	Identify takeaways	• Ask the group for key learning points but add in anything pertinent if it is not covered by the group

Reflection

It is important to allow the participants to reflect on the simulation activity itself before moving through to an evaluation of the entire workshop. Once the debrief has finished, give the learners some quiet reflection time to process the simulation event. After a few minutes, distribute the Participant Reflection form for completion (see appendix 9). Once this has been completed, all participants come together in a large group.

Evaluation and Workshop Close

The workshop has 15 minutes allocated to evaluation and workshop close. This time should be used to check in on the emotional temperature of the whole group and also to recap the learning objectives that the entire workshop set out to achieve and how this was done. This may be an opportunity for participants to ask any clarifying questions about any topics or approaches in the workshop.

The difference between the reflection and evaluation should be emphasised (reflection at the end of the simulation was designed to allow the participants to consider their individual learning from the session while the evaluation focuses on the broader workshop and how effective it was). Hand out the evaluation form (appendix 11) or add QR code to PowerPoint. Remind learners that data will help support funding applications for the workshop to continue and be embedded in the educational program.

While the pre-workshop questionnaire, the reflection, and the evaluation are anonymous, encourage all participants to reach out personally if they have any particular questions or comments they wish to discuss in person.

While there is a lot of data to process, it is important to give all participants a timeframe for closing the communication loop. Allow time for the feedback to be collated, analysed, and responded to by faculty before composing one report for learners and another report on faculty.

Appendices

Appendix 1: References

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12. Café-To-Go-Revised, The World Café Community Foundation, 2015, accessed May 2024, https://theworldcafe.com/wp-content/uploads/2015/07/Cafe-To-Go-Revised.pdf

13. Sidhu S, Cheese F. Geekymedics. OSCE Checklist: Breaking Bad News, Updated November 2023, Accessed May 2024. https://geekymedics.com/wp-content/uploads/2022/08/Breaking-Bad-News.pdf

Further Reading

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- Herzog EM, Pirmorady Sehouli A, Boer J, et al. How to break bad news and how to learn this skill: results from an international North-Eastern German

Society for Gynecological Oncology (NOGGO) survey among physicians and medical students with 1089 participants. *Int J of Gynecol Cancer* 2023;33:1934-1942

- Mansoursamaei M, Ghanbari Jolfaei A, Zandi M, et al. Self-assessment of residents in breaking bad news; skills and barriers. *BMC Med Educ*. 2023;23(1):1–740.
- Cvengros JA, Behel JM, Finley E. et al. Breaking Bad News: A Small-Group Learning Module and Simulated Patient Case for Preclerkship Students. *MedEdPORTA*L. 2016 Nov 22;12:10505. doi: 10.15766/mep_2374-8265.10505.

Appendix 2: Pre-workshop questionnaire

Breaking Bad News Pre-Workshop Questionnaire

Please complete this questionnaire to the best of your ability. Your information will be deidentified and used anonymously both to support the teaching we give to you in today's workshop and also to improve the teaching for future medical students in the course.

1. **Gender**: Male ◯
   Female◯
   Other ◯

2. **Age** _____

3. **Intended Speciality** _____

4. How great is your **fear of delivering bad news**?

No fear 0 **100% fearful** (10)

0	1	2	3	4	5	6	7	8	9	10

5. Would you feel **capable and comfortable** during a conversation where you have to deliver bad news?

No confidence 0 **100% confident** (10)

0	1	2	3	4	5	6	7	8	9	10

6. From your pre-reading, do you have **strategies** in place to deliver bad news?
   Yes◯
   No ◯
   If yes, please expand:

7. Have you **witnessed the delivery of bad news** in the clinical environment?
   Yes◯
   No ◯
   If yes, how did you find the experience?

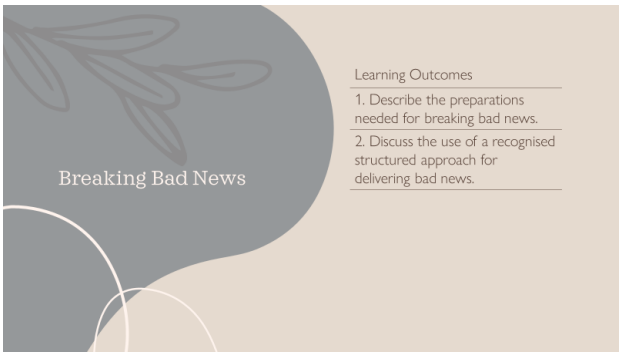
8. Has the topic of delivering bad news **influenced your choice of speciality**?
   Not at all = 0 Completely influenced = 10

0	1	2	3	4	5	6	7	8	9	10

Appendix 3: Review of SPIKES protocol[2]

1.

2.



Breaking bad news – **Introduction**

3.

Why is it **important to learn about breaking bad news**?

4.

SPIKES – divide into 6 groups for discussion.

The acronym SPIKES, stands for Setting up, Perception, Invitation, Knowledge, Emotions with Empathy, and Strategy or Summary. This approach was designed by Walter Baile and colleagues at the University of Texas MD Anderson Cancer Center in Houston TX.[1] The protocol helps healthcare professionals to deliver bad news in a way that helps minimise stress on both the giver and the receiver whilst avoiding under- or over- loading the patient with information. It includes the following steps:

i. Ensure that the setting is appropriate.
ii. Check in with the patient to establish a baseline of the patient's understanding.
iii. Obtain consent to proceed with the amount of information desired by the patient.
iv. Give the information in an understandable format and check in with the patient's understanding.
v. Explore the emotions and respond with empathy and understanding.
vi. Develop a strategy or plan for support and next steps.

Give each group a step. Ask them to discuss what, how, and why of each step. Give each group 5 minutes for this activity.

5.

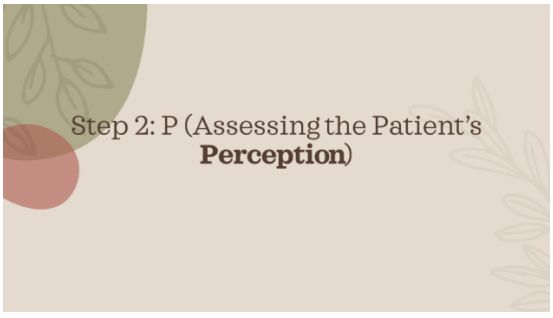
Step 1 – report back from group

Step 1: S – SETTING UP the interview.[2]

Below is an extract from the article as a prompt for the discussion:

- Arrange for some privacy.
- Involve significant others.
- Sit down.
- Make the connection with the patient.
- Manage time constraints and interruptions.

6.



Step 2 – report back from group

Step 2: P – Assessing the Patient's PERCEPTION[2]

Below is an extract from the article as a prompt for the discussion:

Before discussing the medical findings, the clinician uses open-ended questions to create a reasonable accurate picture of how the patient perceives the medical situation, i.e. "What have you been told about your medical situation so far?"

7.

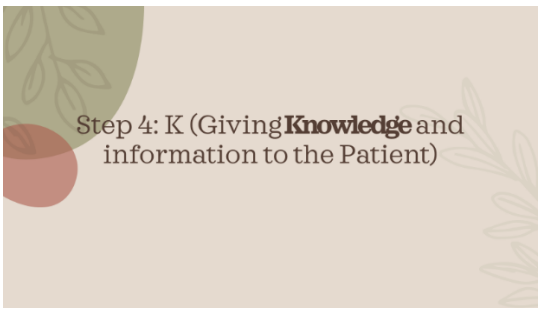
Step 3 – report back from group

Step 3: I – Obtaining the Patient's INVITATION[2]

Below is an extract from the article as a prompt for the discussion:

While a majority of patients express a desire for full information about their diagnosis, prognosis, and details of their illness, some patients do not. If patients do not want to know details, offer to answer any questions they may have in the future or to talk to a relative or friend.

8.

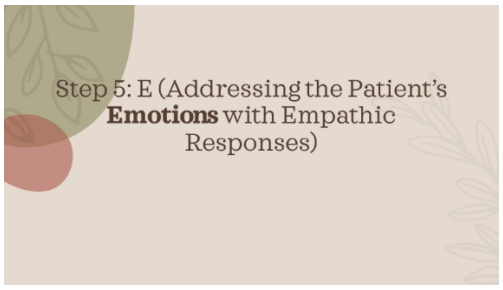


Step 4 – report back from group

Step 4: K – Giving KNOWLEDGE and information to the patient[2]

Below is an extract from the article as a prompt for the discussion:

Warning the patients that bad news is coming may lessen the shock and facilitate processing.

1. Start at the level of comprehension and vocabulary of the patient.
2. Try to use non-technical words
3. Avoid excessive bluntness
4. Give information in small chunks and check periodically as to the patient's understanding.
5. When the prognosis is poor, avoid using phrases such as "There is nothing more we can do for you". This is inconsistent with the fact that patients often have other important therapeutic goals such as good pain control and symptom relief.
9. 

   Step 5 – report back from group

Step 5: E – Addressing the Patient's EMOTIONS with Empathic Responses[2]

Below is an extract from the article as a prompt for the discussion:

- First, observe for any emotion on the part of the patient. This may be tearfulness, a look of sadness, silence, or shock.
- Second, identify the emotion experienced by the patient by naming it to oneself. If a patient appears sad but is silent, use open questions to query the patient as to what they are thinking or feeling.

- Third, identify the reason for the emotion. This is usually connected to the bad news. However, if you are not sure, again, ask the patient.
- Fourth, after you have given the patient a brief period of time to express his or her feelings, let the patient know that you have connected the emotion with the reason for the emotion by making a connecting statement. An example: Doctor: I'm sorry to say that the x-ray shows that the chemotherapy doesn't seem to be working [pause]. Unfortunately, the tumor has grown somewhat. Patient: I've been afraid of this! [Cries] Doctor: [Moves his chair closer, offers the patient a tissue, and pauses.] I know that this isn't what you wanted to hear. I wish the news were better.

Until an emotion is cleared it is difficult to discuss other issues.

Students often find this step the most difficult. Use the whiteboard to discuss responses in the following categories:

Empathic Statements: (I can see how upsetting this is for you; I was also hoping for a better result, etc)

Exploratory questions: (Tell me more about that; Can you tell me what you are worried about?, etc)

Validating responses: (I see you have thought things through; Anyone might have the same reaction, etc)

10.

Step 6 – report back from group

Step 6: S – STRATEGY and SUMMARY[2]

Below is an extract from the article as a prompt for the discussion:

Patients who have a clear plan for the future are less likely to feel anxious and uncertain. Before discussing a treatment plan, it is important to ask patients if they are ready at that time for such a discussion. Presenting treatment options to patients when they are available is not only a legal mandate in some cases [68], but it will establish the perception that the physician regards their wishes as important. Sharing responsibility for decision-making with the patient may also reduce any sense of failure on the part of the physician when treatment is not successful. Checking the patient's misunderstanding of the discussion can prevent the documented tendency of patients to overestimate the efficacy or misunderstand the purpose of treatment [7-9, 57].

11.

Any questions – clarify any concerns about the protocol.

Appendix 4: Barriers to Breaking Bad News (World Café Approach)[12]

Purpose of session:

- Discuss the barriers to the delivery of bad news.
- Explore the strategies to facilitate the delivery of bad news.

Two groups of 20 in two break out rooms, three facilitators in each room. Explain the purpose of the session and the world café approach. (See Café to Go PDF and the Self-assessment of residents in breaking bad news; skills and barriers article for reference)

In each group of 20, move the students into three smaller groups. There will be three large Post Its positioned around the room with the following headings:

- Healthcare provider
- Institutional/Environmental
- Patient/Family

Each group starts at one of the Post Its and brainstorms barriers under each heading for 4 minutes at the first heading, 3 minutes at the second heading, and 2 minutes at the third heading each time building on the work of the previous group. Ensure that there is a facilitator near each station to prompt and support if necessary.

The groups stay at their last station and new Post Its are placed beside the lists of barriers. The new Post Its are labelled Strategies. The groups are given 10 Minutes to discuss solutions before coming together as a large group. (If desired this could be a

large group of both break out rooms). Each group is given time to present their barriers and strategies with input from the whole group.

Before the end of the session, take photos of the Post Its so the discussion can be collated and emailed out to the cohort.

Appendix 5: Mr White's Laboratory Results

(Adjust and print to fit laptop screen)

David White: MRU1111

DOB: 12.11.1954

PSA – 4ng/ml

PSA above 3ng/ml may indicate prostate cancer but there may be other causes for the raised level which the GP had explained to Mr. White.

David White: MRU1111

DOB: 12.11.1954

Adenocarcinoma of the prostate, grade 3

The grade given to prostate cancer describes how aggressive the cancer cells are. This grading is known as the International Society of Urological Pathologists. Grading happens at the time of diagnosis, using the prostate biopsy sample. It is assigned a grade from 1 to 5, with 5 the most aggressive on the ISUPS Grade Group system.

Appendix 6: Simulated Patient Feedback Sheet (Adapted from OSCE Checklist: Breaking Bad News[13])

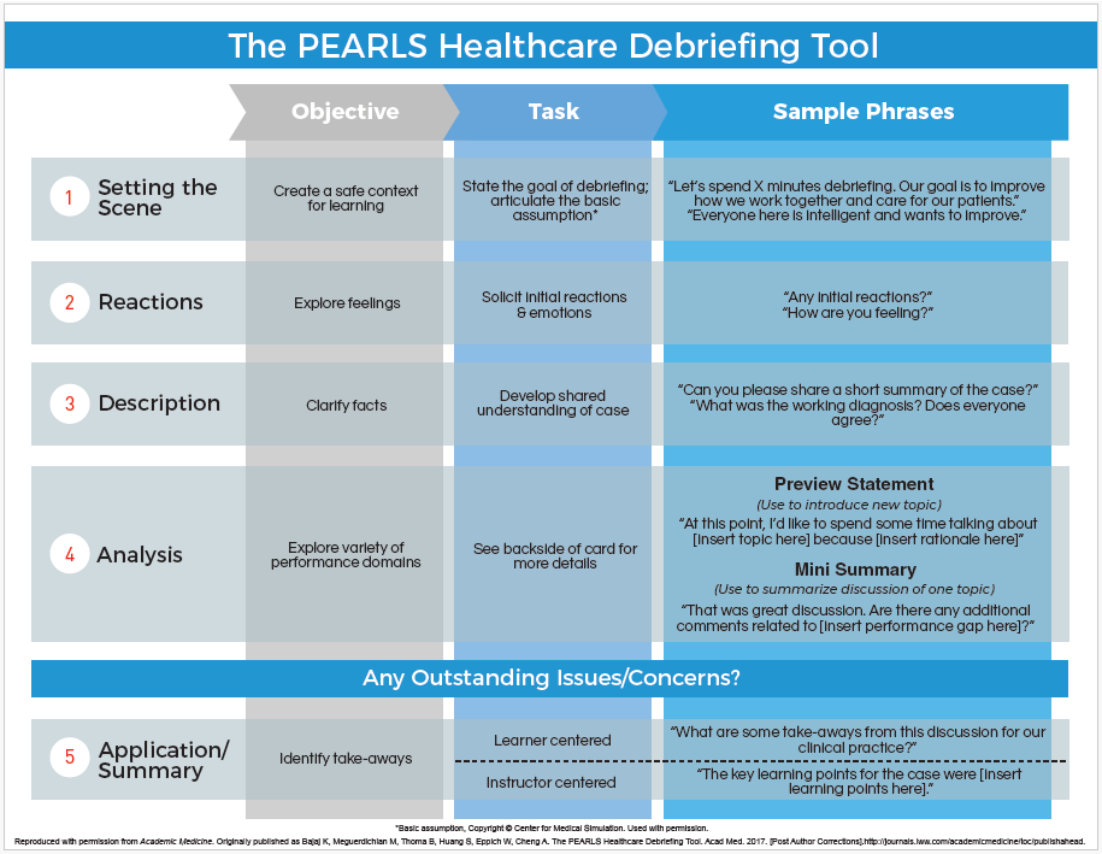
Opening the Consultation		Comments	Tick
1.	Doctor washes/sanitises hands		
2.	Doctor introduces themselves to you including their name and role		
3.	Doctor confirms your name and date of birth		
4.	Reason for the consultation explained		
5.	Consent to continue with the consultation obtained		
Setting			
6.	Room is set up appropriately		
7.	Doctor offered to have another person present with the patient's consent		
Perception			
8.	Doctor explored the sequence of events leading up to the consultation to establish what you already know		
9.	Doctor identified any specific patient concerns		
Invitation			
10.	Doctor checked if you wished to proceed with the consultation and be given the information		
Knowledge			
11.	Doctor gave a warning shot prior to breaking the bad news		
12.	The information was delivered in sizeable 'chunks' using simple and clear language		
13.	The doctor used pauses to allow you to process what was told after each 'chunk'		
14.	Questions were answered appropriately, without providing false hope or inaccurate information		
15.	Medical jargon or euphemisms was avoided		
Emotions and Empathy			

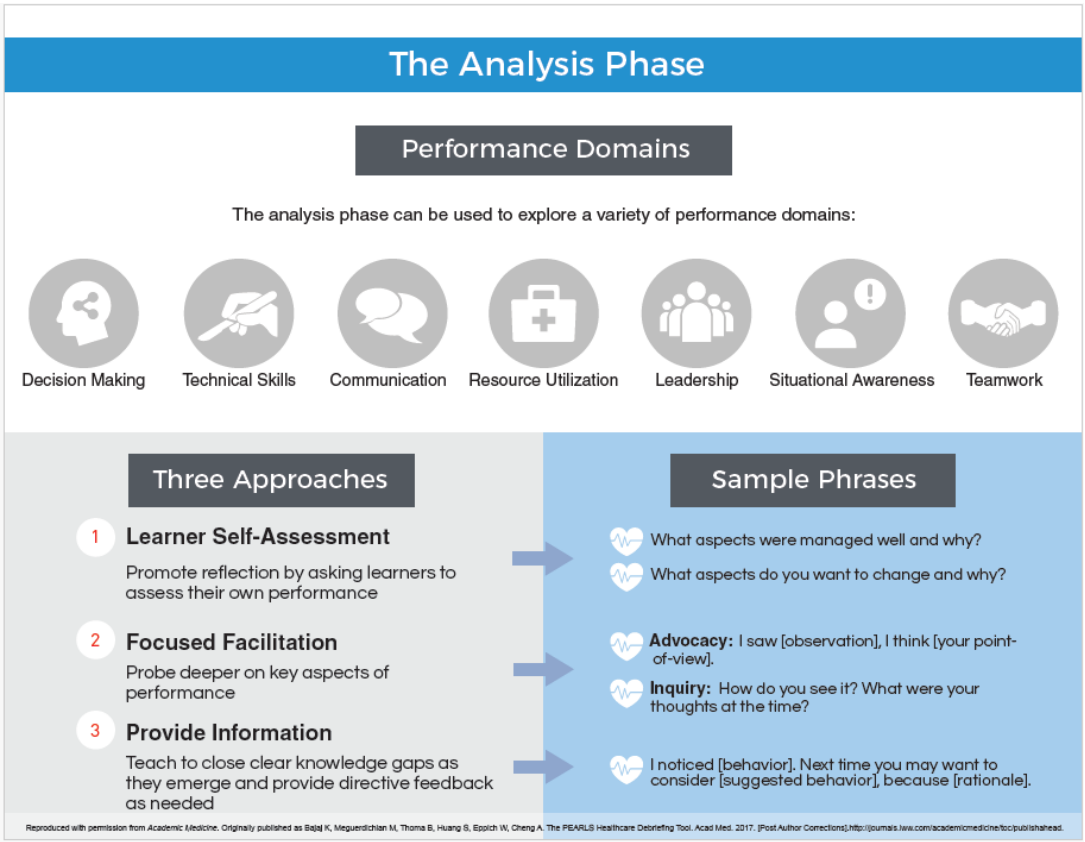
16.	Your emotions were recognised and responded to with empathy (verbal and non-verbal)		
Strategy and summary			
17.	A clear plan for next steps (e.g. specialist referral, follow up appointment) was provided		
18.	Your understanding was summarised and checked		
19.	Any misunderstandings were clarified (if required)		
20.	Assistance was offered to tell others		
21.	Signpost to sources of further information was given		

Appendix 7: Observer Feedback Sheet (adapted from SPIKES protocol[2])

SPIKES Protocol Observer Sheet			
1. Setting	**Comments**	**Yes**	**No**
• Sits down with chair facing in optimal position			
• Establishes rapport with patient			
• Demonstrates verbal and non-verbal communication skills			
• Limits interruptions			
• Offers to have another person present			
2. Perception	**Comments**	**Yes**	**No**
• Checks what the patient knows already			
• Checks in with how patient is feeling now/specific concerns			
3. Invitation	**Comments**	**Yes**	**No**
• Checks patient's readiness to receive information			
• Checks how much information patient wants			
4. Knowledge	**Comments**	**Yes**	**No**
• Provides forewarning to the bad news			
• Delivers information in manageable chunks			
• Answers questions appropriately			
• Uses clear non-medical language			
5. Emotions/Empathy	**Comments**	**Yes**	**No**
• Allows patient to express emotions			
• Responds empathetically to patient's emotions			
6. Summary/strategy	**Comments**	**Yes**	**No**
• Asks patient about readiness to receive a plan			
• Outlines next steps			
• Clarifies patient's understanding			
• Offers to answer any questions/provide sources for information			
• Offers support to tell others			

Appendix 8: PEARLS[11]





Appendix 9: Participant reflection

1. How great is your **fear of delivering bad news** after participating in the simulation?
   No fear 0 100% fearful (10)

0	1	2	3	4	5	6	7	8	9	10

2. Would you feel **capable and comfortable** during a conversation where you have to deliver bad news after participating in the simulation?
   No confidence 0 100% confident (10)

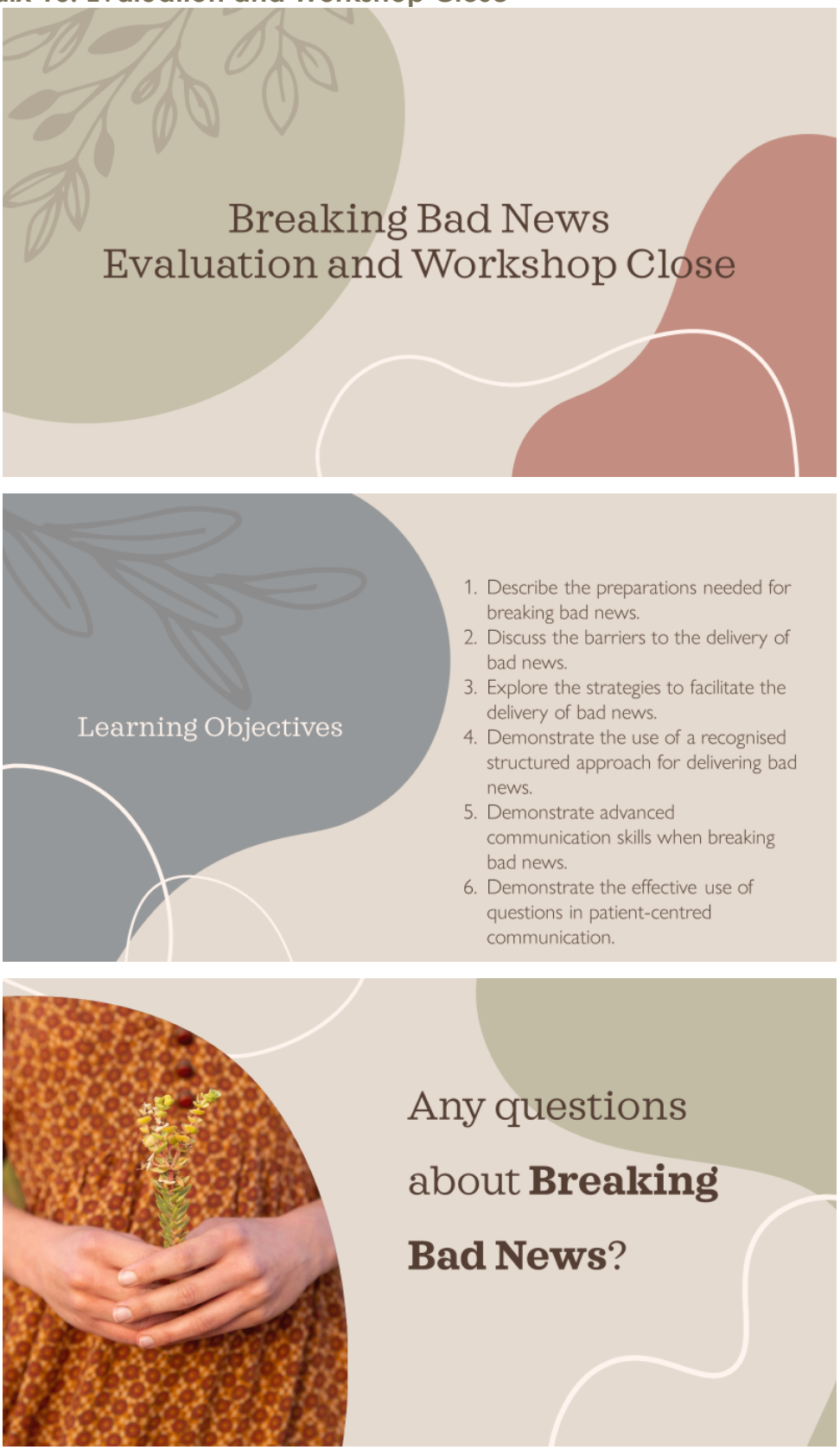
0	1	2	3	4	5	6	7	8	9	10

3. Have you more **strategies** in place to deliver bad news after taking part in the simulation?
   Yes◯
   No ◯
   If yes, please expand:

4. How did the simulation meet the **learning objectives**?
   - Demonstrate the use of a recognised structured approach for delivering bad news.
   - Demonstrate advanced communication skills when breaking bad news.
   - Demonstrate the effective use of questions in patient-centred communication.

5. Please write down one thing from the simulation that you can **use in the clinical environment**.

Appendix 10: Evaluation and Workshop Close




Reflection v
Evaluation


Thank You
FACULTY CONTACTS:
• BRID PHILLIPS brid.phillips@uwa.edu.au
• Add other faculty members here

Appendix 11: Evaluation Sheet

Participant Evaluation (both learners and faculty)

Date of training session: _____

Medical Student (or profession and grade): _____

What role did you play in the scenario (optional)? _____

1. **Were all the learning objectives achieved?**
   Yes◯

   No ◯

   If yes, please expand:

2. **How did you find the workshop and its materials?**

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
I understand more about breaking bad news					
I have more confidence breaking bad news					
The material covered was relavant to me					
The simulation was useful to me					
The revision of SPIKES was useful to me					
The discussion on barriers and strategies was useful to me					

3. **What were the most useful parts of the workshop?**

4. **How could the workshop be improved for future participants?**

5. **Would you be happy to be contacted in the future regarding the breaking bad news program?**

   Yes◯

   No ◯

   If yes, give your contact details:

Many thanks for your time. We will endeavour to get the results of the feedback, barriers and strategies for breaking bad news, and reflections to you as soon as the information has been processed and analysed.