

# The Role of Multidisciplinary Teams: A Focus on Communicating Bad News

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## Abstract

Communication is one of the key processes of being human, furthermore, being a good communicator can help with building good quality relationships between people. Communication may be used to construct a mental image of individuals. The paper focuses on the research and results of a study concerned with the quality of communication between parents and doctors. From the findings of the study, quality communication can be used in the therapeutic intervention and practice, when bad news has to be conveyed by medical practitioners to clients and/or patients. The target group for the research was parents of children with hearing impairment. The authors present results pointing to a possible remedy of the issue of communicating bad news.

## Keywords

**Doctor, Child, Disability, Parents, Communication, Bad News**

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## 1. Introduction

When communicating the bad news to clients and/or patients or parents of patients about a hearing impairment, experts should have sufficient time to meet and talk with the family about the medical situation. Communicating a diagnosis, in this instance breaking the bad news about the hearing impairment of a child, is the focus of the research conveyed in this paper.

When learning the bad news about a child's hearing impairment, parents usually have very little information about hearing defects and/or hearing loss, what opportunities are available to help compensate for the hearing impairment and other related issues. Taking any step that affects their child's future and coping with a hearing impairment is for them a long and emotionally arduous process [1] [2]. Initially, therefore, it is the parents who need help in adjusting their perceptions of hearing impairment and the impact upon their child and family. As Vymlátílová states (in Říčan, Krejčířová, 1997) [3] [30], from the first meeting the parents' feelings and opinions must hold equal importance with the child's diagnosis, as this will affect the future of the child and the family as a whole as stated Regec (2012) [28]. It is surmised that the way in which professionals work with parents and communicating the essential diagnostic information is crucial. In addition, parents' rate information provided by medical and special education practitioners as the most important sources of information, which was confirmed by

research conducted by Potměšil and Pospisil [4]. Wigert *et al.* [5] and Orioles [6] research studies focus on the communications by staff of neonatology departments and parents, and define areas of communication skills such as empathic, informative and communicative behaviours that need to be improved. The studies yielded eleven parameters that parents considered critical for acceptable communication: Empathy, availability, individual access to the child, respect for parents' knowledge about the child, leaving room for hope, body language, diligence, care above and beyond professional duty, responsibility, willingness to listen to questions, and sensitivity to the child's suffering.

Further considerations for practitioners to be aware of and to develop are a respect the need for adequate space when communicating bad news to parents. Michalik states [7]: "When communicating the news to the patient or his family (typically the parents of the child), you must respect two aspects of this rule. The first is the spatial expression of this need, *i.e.* simply put, adequate space to provide seamless communication, noise-free and adequately equipped with appropriate furniture (a laboratory full of strange devices and flashing monitors is inappropriate). Likewise, corridors in the hospital, the doctors' room where other colleagues are writing reports, etc., are totally inappropriate. A second aspect of the same rule is to create a space for communication in the mind of the communicator (usually the doctor). The patient must feel (and considering that from that moment feelings will be remembered more than anything else) that the medical worker wants to pay attention to them, has time for them, and that communicating this news is not a burden, but that, while maintaining professional distance, the content being communicated to the recipient contains the necessary amount of empathy."

**Behavioural indicators.** According to Vymlátílová, (2003) [8] there are signs indicate when a patient and/or parent(s) is in crisis concerning diagnosis. These behaviours are depression, vegetative symptoms and a significantly reduced ability to process new information. Vymlátílová, (2003) [8] further points out that the speed and manner in which the family member adapts to the new and difficult situation is significantly affected by the way in which the diagnosis was communicated to the child's parents in the early stages. According to Potměšilová [9], another important factor in the communication of bad news is the ability to initiate such dialogue in an appropriate manner. Positive physical behaviours identified include: eye contact, expressions of interest by the practitioner, a friendly demeanour and speaking at eye level to the client in order to reduce the feeling of submissiveness. In respect of communication conducted by a multi-disciplinary team, members should employ a breadth of comprehensive care behaviours that incorporate the following [10]:

- providing a responsive and honest method of communication
- allowing the presence of both parents during the discussion
- providing subsequent support for both parents
- offering the possibility of the child's presence
- demonstrating the doctor's (psychologist's, speech therapist's and other team members') approach to the child
- allowing repeated discussion about the child
- involving grandparents and siblings in the discussion

Resistance type behaviours that have been found to occur in stressful situations include the inability to use positive incentives, in particular the ability to maintain social contacts, to accept offers of help and to communicate about the problem.

Positive behaviours can include assistance, which is often understood in terms of social support, and can be realised as support from families, friends, partners, wider social networks, and the help of professionals [11]. Vágnerová [12] points out that it is important for "any support of this kind to be available and that the affected individual is able to recognize, accept and use it. The absence of support is both a cause and a consequence of various psychological problems."

**Social environments.** The social environment in which a child with hearing disabilities grows up determines not only the quality and quantity of acquired experience and skills, but also the emotional relationships that are formed between the child and other family members [13]. A parent's inability to cope with their child's health condition and the resulting feelings of personal failure has a negative impact on the child's emotional and cognitive development. Following an objective confirmation of a hearing impairment, parents face several months of uncertainty about which direction to take to help their child's hearing deficit, for example, whether to choose a hearing aid and the use of such technology in the short term, or whether to opt for a cochlear implant, speech therapy and long-term adjustment [14]. Crossley [15] focuses on the evaluation of communication skills with parents, physicians and paediatric patients in his research and uses his own tools for authentication as well as for obtaining feedback for the physician.

Martin, Bat-Chava, [16] and Stejskalová [17] emphasize the child's personality characteristics, which offer a different perspective on the diagnostic process and conveying bad news. The afore mentioned authors seem to suggest a subjective evaluation of stressors that act on a child is related to an evaluation of the child's ability to cope with adverse life situations, however, children usually have a more limited range of coping strategies than adults. Furthermore, essential aspects for practitioners to consider are that children have fewer opportunities to make decisions about their own lives. Important decisions such as whether to opt for a cochlear implant, for example, are usually made by the parents, and the child's participation in the decision-making process is minimal.

The author Zaidman-Zait [18] states that even the best professional assistance and support cannot influence parents' experiences. Psychologists, teachers, speech therapists and other professionals should be aware that even when they provide the best support, the most comprehensive information and the soundest advice with the highest degree of empathy, parents are still on their own when resolving problems concerning their child's best interests. This might be a consideration in cases when the family ignores well-intentioned advice offered by professionals. Thus, it is necessary to strengthen parental feelings of competence when dealing with their child, and also to strengthen the confidence and competences of siblings of individuals with hearing disabilities [19].

## 2. Methodology

The current study employed a questionnaire that focused on the process and form of cooperation between parents of children with cochlear implants and professionals who were part of the medical (?) team caring for the child. Given that the research was multi-dimensional, the respondents, namely the parents of children with cochlear implants have been reported in this paper.

**Participants.** There were forty-nine respondents—parents of children with cochlear implants. All of the parents have normal hearing. In most cases the questionnaires were filled out by the mother (92%). At the time of the research the oldest child was 14 years old and the youngest was eight months. The gender distribution of the children with cochlear implants among the respondents was 47% girls and 53% boys.

**Instruments.** The questionnaire comprised Parents rated the teamwork, quality and quantity of information obtained from experts based on their experience. The parents responded to the statement on a scale of 1 - 5. A separate section of the questionnaire was devoted to statements to which the parents were asked to respond on a **scale of 1 to 5 (1 = mostly agree, 5 = mostly disagree)**. Participants could also answer by saying "I don't know", which in many cases had an informative value for us (e.g., "Our paediatrician, if necessary, communicates with other experts and consults with them.").

To evaluate the issue from the parents' perspective, **semi-structured interviews were conducted, recorded and transcribed as a verbatim record. Interviews lasted for approximately 30 minutes. Questions used in the interviews** highlighted and illustrated the current state of cooperation between parents and professionals.

The specific questions designed to obtain data from the interviews primarily focused on the following areas:

- The atmosphere in the family, family background.
- Characteristics of development (educational process, cooperation with experts, family context, the process of socialization, personality characteristics).
- Characteristics of communication with experts (accuracy, completeness and clarity of the information, advice, empathy level, overall approach).

**Data analysis.** As stated by Stejskalová [17] "an integral part of the data management phase is data systematization—making it easier and faster to work with qualitative data is a prerequisite for subsequent analysis and interpretation." (Hendl in Stejskalová, [17]) presents four techniques for transcribing the text material obtained in our case by means of the semi-structured interview method: literal transcription, commented transcription, a summary report and a selective report. Due to the relatively good knowledge of the subject based on the study of the literature and personal experience, the team of researchers considered the use of the summarizing report technique as the most relevant for data analysis.

With the participants consent, interviews were conducted in the pleasant environment of a building where a summer meeting organized by SUKI (Association of Cochlear Implant Users) took place. During the initial phase of the interviews, respondents were presented with basic information about the meaning and purpose of the research. Informed consent was obtained which particularly related to the handling of sensitive data. In addition, the progress and content of the interview was outlined and, respondents were informed of their option to refuse to answer any questions or to end the interview if they found the experience unpleasant in any way. This created a friendly and relaxed and safe atmosphere. Validity of presented research was supported by consequently organ-

ized open discussions with the target group where experiences and statements were confirmed.

### 3. Results

Given that the research was multidimensional, only a portion of the results are reported that focus on a group of parents of children with cochlear implants.

Parents rated the quantity of information received from experts (“**We get enough information from the experts**”) with an average mark of **1.92 (standard deviation 0.975)**. From this general question we can therefore deduce that parents are generally satisfied with the amount of information received. With regard to the availability of information, one of the respondents added the following:

R3: “... when I feel that I don’t have enough information or if I don’t understand something I look for it on the Internet. Internet forums, where users of cochlear implants and parents of these children share their experiences and impressions, really help me. Publications with case studies of children with implants would also be helpful.”

A small note here relating to the nature of information presented in electronic media: The main source of information should without doubt be a knowledgeable expert or team of experts, not an electronic source. Nevertheless, psychologists describe the effect of similarity, *i.e.* the ability to share similar problems and experience the same situation, and internet forums can be one way to facilitate the process of accepting the bad news of a hearing impaired child.

The statement “**We received instruction on how to monitor the development of the child’s speech after cochlear implants**” received an average rating of **1.84 (standard deviation 1.264)**. The interviews show that parents received instruction on how to monitor the child’s speech after cochlear implantation in particular from Tamtam centres of early care and from the CKID.

R2: “*In Tamtam and the CKID (Centre for Cochlear Implantation in Children) they told us that we need to follow the development of speech after implantation. In Tamtam they even helped us with the choice of communication methods for our child.*”

On a scale of satisfaction the results had an average mark of **3.06 (standard deviation 1.590)** demonstrating that parents are generally **dissatisfied with the manner in which they were told about their child’s hearing impairment (the assertion “I am satisfied with the way the doctor told us about our child’s hearing impairment”)**. The respondents reported that the staff’s approach was rather formal. Information was presented openly, but without much emotion. The results are documented in several responses from the interviews.

V: “*Do you have any major negative experiences you would like to share?*”

R6: “*The first I can think of is my negative experience with how the information that our child has a hearing impairment was communicated... The doctor first said it was a cold and that we should come back in two months. At the time I said I wouldn’t leave it like that and so I turned to someone else, and I’m very glad I did. Losing two months would have been a big mistake.*”

Another respondent answered the same question as follows:

R2: “*I was angry that no one would believe me that my child can’t hear. Everyone told me that my child just doesn’t listen, that it was somehow my fault. When it was confirmed that our child has a hearing defect, we were surprised by the phoniatrist’s approach—he seemed unable to empathize with our situation. We had to find out everything ourselves—from acquaintances, via the Internet. It seemed to me that two months was a long time to wait for a hearing aid, so we had to arrange everything ourselves. We attended speech therapy and Tamtam before he had a hearing aid. I think it would be best if they gave us a lot of pamphlets about everything we can expect and we would study everything calmly ourselves. It would be better to tell us: once you’ve read it all, here is our phone number, give us a call.*”

Another respondent (R1) answered the question “*In your opinion, which area of care should change for the better?*” as follows: “*Well, I think that above all the experts’ approach in communicating bad news such as a hearing impairment should change.*” Then she added: “*I can’t change what happened to us, but I hope it never happens to anyone else.*”

Here we want to emphasize the individual process of accepting bad news about the health of a child. At the same time, it is not only parents who report an apparent lack of awareness on the part of health professionals in communicating with the patient in the sense of a lack of understanding about the characteristics of the phase of shock and denial of the child’s disability. Although this problem may only be local, it nevertheless cannot be ignored due to its effect on the lives of people with hearing impairments and their families.

Overall, the respondents assessed the cooperation with experts at various levels of care and services rather negatively, both in terms of access and in terms of the information provided. We can also trace the many negative experiences of parents who describe an inappropriate (arrogant, haughty) approach by experts, which was confirmed in the interviews.

The average mark on the scale of satisfaction about the assertion **“Our paediatrician monitors the performance of our child’s auditory function throughout childhood”** was **“2.71”** (standard deviation 1.468). Worth noting, however, is the evaluation of this assertion by eight respondents, who gave it a mark of “3”, seven respondents who gave it a mark of “4” and seven other respondents who evaluated this assertion with a mark of “5”. The question remains as to how the paediatrician's role is perceived in the overall care for a child with cochlear implants, not only by parents, but also by the paediatricians themselves.

One of the respondents explained their dissatisfaction as follows:

R3: *“When I told the paediatrician that I felt that my child can’t hear, he told me that I was an overly frightened mother and that I was watching my child too much.”*

Another respondent discusses her paediatrician's level of knowledge:

R4: *“We did not get any information from the paediatrician; on the contrary, we provided the information to him.”* At the level of cooperation with the experts participating in the care of children with cochlear implants and their families, the results related to the distribution of information, access to experts, levels of empathy and cooperation at the trans-disciplinary optimization level should reflect comprehensively conceived treatment for persons with hearing disabilities and improve their quality of life.

#### 4. Discussion

Improving the teamwork skills of professionals who understand the problems of hearing impairment and have empathy and understanding is recommended. When communicating the bad news about hearing impairment all experts should have sufficient time to discuss the situation with the family. In this regard, we recommend that medical facilities train their staff on communicating effectively with families, especially when confirming hearing impairment. This education should not only include issues of deafness as a scientific and medical focus, but also the possible aspects of the positive effects of hearing impairment for the child and the whole family.

At the level of cooperation with experts, the characteristics of trans-disciplinary collaboration should be reflected in the optimization of services for clients with cochlear implants and their families. One of the bases is paediatric—neonatology care. In our opinion, the main ideological pillar is care focused on achieving optimal health of the new-born and cooperation with other experts [20].

The paediatrician—neonatologist should ensure that the mother of a child with hearing impairment is educated in the area of preventing upper respiratory tract infections to which these children are particularly sensitive; they should also be provided information on other related care for achieving optimal health, especially when preparing the child for cochlear implantation [21].

The family should have an adequate amount of material to take home and study. These materials should contain all the available information about the cochlear implantation centre, wound care and organizations to which they can turn.

One of the questions examined the frequency of visits by experts who are part of a multidisciplinary team for children with hearing impairments. Parents should evaluate the frequency of visits by each expert separately, with the possibility of assessing experts that are visited due to other related problems suffered by the child. As we expected, this produced interesting data such as the item “psychotherapist”. The results showed that only four parents visited a psychotherapist. Another reason for not using the services of a psychotherapist may be lingering prejudices and stereotypes among the general public, in our case the parents. The lack of information provided to parents by experts may also play a role. The results can also be demonstrated by the respondent's answers obtained from the interview:

V: *“In your opinion, what area of care should change for the better?”*

R1: *“Help for the family—so that we know how to accept the fact that our child has a hearing impairment and to work with this information... I think we lack care from the psychotherapist.”*

From the statement **“The psychotherapist provides information on how to care for the child, how to raise them, how to work with and communicate with them”** it followed that sixteen parents do not know if the psychotherapist provides information on communicating with the child. This is probably the result of the fact that these parents do not visit a psychotherapist. In the context of the effectiveness of the communication of bad news

and, based on many studies (e.g. [22] [23]), it can be generally recommended that psychotherapy services be integrated as a completely natural part of services across the age spectrum.

## 5. Conclusions

Our recommendations are directed towards cooperation with experts who are part of a team caring for clients with hearing impairments and their families. Those are especially health workers, in terms of the issue of communication with the family, empathy, communicating bad news in an adequate manner, acceptable and clear form. We recommend that parents be fully involved in the process of treatment, which is the most important component, as well as have the opportunity to fully monitor and assess the effectiveness of the services provided and to provide professionals with feedback which correlates with findings reported by Ruzickova (2008) [29].

We place great emphasis on the increasingly acute need for further training of health professionals, but also people in related professions. In this context, it is in our view necessary to increase the trans-disciplinary level of care and services. Orioles *et al.* [6] as well as Wigert [5] illustrate the results of a sample of 270 parents with the same requirements.

Our study has shown that there is dissatisfaction with how medical staff communicates information to families. Similarly, Ejaz *et al.* [24] discuss the communication shortcomings of the majority (65%) of doctors at the hospital in Karachi. We also consider it desirable to support and develop the intensive participation of families in terms of active cooperation, not only with the medical staff of cochlear implantation centres, but also early intervention centres and special pedagogical centres.

After parents overcome the initial shock, it is necessary to ensure that have continuous access to information and to strive for comprehensive family support from professionals at all levels of care. The level of communication with family largely predicts the success of the treatment process [25]. One of them is respect for ethnicity [26], a fact that is starting to be discovered in numerous professions. Similarly, Farrell [27] draws attention to the possibility of improving communication as an otherwise effective tool.

Apart from the research work, the authors focused on designing and implementing courses for medical staff. Based on theoretical and practical experience in communicating bad news, courses were held as part of a project of the Union of Employers' Associations of the Czech Republic entitled "Effective communication with patients, relatives and close persons", with a focus on communicating with persons with special needs (the author of this article was the lecturer). Ongoing courses were intended for healthcare professionals from selected health care facilities in the Czech Republic. These courses aimed to improve communication with patients with special needs, their relatives and other close persons, including communication for the prevention and management of aggression. The course intended for healthcare professionals from non-medical facilities covered the principles of communication with patients with special needs. In 2010-2012 the course was attended by 280 health professionals in eight regional capitals of the Czech Republic.

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