tunning head: EFFECTIVE PROVIDER-PARENT COMMUNICATION Examining 1← Provider Communication: Parents	Formatted: Right: 0.25"
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Examining Effective Provideratient-Parentrovider Communication of Bad Newswhen a young	
child is suspected of having a serious medical issue	
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Marshall University	

Abstract

This study was configured towill examined patient-provider communication from a parent's perspective. Research shows communication between patients and providers to be important; however if when a child is too young to understand their diagnosis, the parent is left to make sense of iis often the focus of the patient-provider communication. Parents often report not having effective communication with their children's physicians, especially when the doctor shares bad news about the child's health. The need for effective communication becomes especially important when the provider must give the parents important information to help them make the best decisions about their child t. This research project soughteeks to understand what factors influence parental perceptions of effective communication by providersphysicians when giving bad news about a child's health. This study will examine how the breaking of "bad news" effects a parent. If there is a link between empathetic providers and the credibility of those providers.

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Doctor's visits are not seen as a fun experience for anyone; there is often fear of what bad news may come from the appointment. When a parent takes their young child to a provider, many different types of fears enter their thoughts. Those fears can slowly become realities, as they did for Amy Markoff Johnson, who described her experience in an article for the Huffington Post (Johnson, 2012). She and her husband worried about their son's development because of his lack language abilities. They explained these worries to their son's pediatrician and received a statistic explaining that many children do not have comprehendible language until they have reached the age of two. Once her son reached his second birthday with no real progression on his language, a series of tests began. It wasn't until a year later that the term Autism was even mentioned; , but this was not a diagnosis, but the parents "should be prepared." After months of speech therapy, there was a lot of improvement within their child, however there were still "atypical behaviors" which caused concern. It wasn't until Amy's son turned four years old that a neurologist finally diagnosed him with Autism. Two and a half years of parental concern only resulted in the providers shying away from a diagnosis. The main communication message to the parents was to "prepare," but not giving an answer to their question: what is wrong with my son? (Johnson, 2012).

Unfortunately, similar stories of provider physician concerns and parental hesitations could be presented. Overall, Tthere are serious communication issues in provider-parent communication that are ultimately delaying needed care for children. Hesitations are not the only communication issue. Parents are becoming increasingly aggravated with the terminology jargon used by providersphysicians to diagnose their children, that is often offered with little to no explanation. ProvidersPhysicians additionally are not often trained to becoming any more

comfortable with telling the patients bad news (Barnett, 2004). The arguably most difficult thing to tell a patient is a 'bad' prognosis, especially in children, and yet there still isn't much training on how to tell patients this important information (Committee on Children with Disabilities, 2001). Additional research is needed to examine how parents and providers determine effective communication and ways to build the provider-parent relationship that allows for timely treatment for children.

Physician and Parent Communication About Bad News

Parents prefer open communication between their child's pediatrician and themselves. If they have open communication ommunication, then they feel more likely to ask questions if there is any confusion. Provider Physicians must listen carefully to parental concerns so that they may address any issues early on. When a parent shows concern, the initial provider pediatrician should attempt to address the direct concern immediately. (Committee on Children with Disabilities, 2001).

<u>Provider Physicians</u> have avoided prognosis when they feel a <u>patient parent</u> may not know what is ahead. Although it may make the <u>provider physician</u> uncomfortable, <u>many</u> parents <u>report that</u> have made it clear that they prefer to know about the prognosis to help create some sort of ease to their own thoughts. Many parents find being informed on their child's prognosis helps so they may decide upon the best route of care to take (Mack & Joffe, 2014). It is <u>clear</u> parents want to be informed no matter how difficult the news is to hear. The information, when thoroughly explained and understood, improves their since of hope (Mack & et al., 2006).

Communicating 'Bad News'

If the delivery of bad news is done well and at the proper time, it can provide a mutual trust between the patient and physician, which is necessary for the possible long journey ahead

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Commented [A1]: This is not necessarily true—there is research that shows parents will resist diagnosis of their children—especially in a disability context.

So, what you need to do in this section is qualify your statements sometimes it's the physician who is the main problem, but sometimes it is parents who do not want the bad informatio

together (Barnett, 2004). Unfortunately, there are many barriers to effective communication of bad news. Clinicians have hard time breaking down bad news to patients for several reasons. In a case where a patient is diagnosed with cancer the bad news sometimes comes in stages: initial diagnosis, treatment progression, and possible secondary spread (Source). When a providerphysician must deliver bad news, it is difficult for them because of their sense of failure, even if there was nothing the provider could have done to prevent the diagnosis. Another difficult issue is the agreement between providers on the diagnosis. If a patient should choose to get a second opinion and it differs from the initial diagnosis even slightly, doubt of both of the provider's' credibility comes forth. If the delivery of bad news is done well and at the proper time, it can provide a mutual trust between the patient and physician, which is necessary for the possible long journey ahead together. (Barnett, 2004)

Another major barrier to the effective delivery of bad news is the emotional processing of the patient. Bad news is rarely accepted when first hearing it (Morse, 2011). Medical providers need to be more prepared when a parent has disbelief of the diagnosis (Fallowfield, 2004). Many patients are not prepared to hear the information that they need to know. Setting the tone of the discussion by giving the parent options to bring emotional support with them is important.

Physicians Communicating Bad News to Parents

Research has identified best practices for providers communicating with parents. Pacing the conversation when giving the initial diagnosis is key to helping the parents understand the depths of their child's health. Giving clear, simple language at the first diagnosis helps <u>parents</u> to absorb the news fully (Barnett, 2004). Most of the time a physician's emotional support level when explaining negative news can create a less stressful outcome for the parents (Gemmiti, 2016). However, that is not always the case. Sugar coating a diagnosis may seem more humane,

buthumane but is not seen as a desirable method to many parents (Sices, 2009). Parents find the time of which they are given the diagnosis of their child to be crucial. The parents and children express a lack of trust when a pediatrician is calling for testing and not explaining the reasoning behind it (Konstantynowicz, 2016).

Parents too often are not feeling as if they are being heard when voicing concerns on their child's developmental rate. Physicians giving a scripted answer to these concerns causes the parent to feel they are justified in blaming the physician for not catching their child's diagnosis earlier on (Committee on Children with Disabilities, 2001). Timing is crucial with diagnosing children. Early intervention is known to help the outcome of the child's life. Giving bad news to patients doesn't have to be a scary thing (Krahn, 1993). Knowing the full prognosis of their child in plain and simple language to its full extent has helped parents to feel a sense of hope even though there isn't much they can do (Mack, 2014).

Effective Provider-Patient-Child Communication

Providers' attempt to try to answer all a parent's questions in a closed question format of yes and no answers causes parents to feel the provider lacks any interpersonal interest in the family's well-being. Northwestern University recognized this issue amongst providers' bad news delivery and developed a communication program center around the proper technique to deliver negatively perceived news. The American Academy in Communication in Health Care (AACH) also designed intensive training modules on communication to improve residential skills when describing to a parent how their child's lifelong disability developed (Levetown, 2008).

After taking these classes providers' have shown improvement in their approach to communication. Connecting with the parents in a concise and understanding manner helps

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parents to be a part of their child's impending health decisions. Time spent to learn how to express interpersonal sensitivity with patients has long term benefits such as greater patient outcome and satisfaction as well as professional achievement. If the parents feel as if the provider is uninterested during the consultation then the parent may reveal less to the provider causing sometimes no further action on the child's health to be taken (Levetown, 2008). Parents want communication to be informative, interpersonally sensitive, and partnership building.

The empathetic nature of providers creates an open discussion environment (Sices, 2009). If a provider shows a lack of sensitivity to the severity of the situation with a pessimistic outlook parents become more hostile (Krahn, 1993). An givegives one paragraph to the importance of expressing empathy, one on physician credibility, and one on how physicians can help persuade parents to take further actions to help their children.

Synthesis Section

Most medical schools offer little training on effective communication strategies. Because of their training, most providershysicians tend to focus on providing information to their patients and are often not as concerned with interpersonal sensitivity. The lack of interpersonal dynamics often leads patients to feel misunderstood and devalued by their medical providers. Overall, more patient-centered communication is needed; this is especially true for providershysicians working with parents of young children.

A myriad of communication strategies are currently used by providershysicians when giving parents of young children bad news. Whereas some providershysicians adopt a straightforward informative style, others physicians try to adopt very positive eaffective tones to lessen the severity of the information. The language and communication style that

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providershysicians use when communicating with parents can shape the families' understanding of the situation and decision_making process. Therefore, it is vital for health communication research to provide guidance on what strategies may be effective for providershysicians.

Currently, the literature has mixed findings on the role of provider'sphysician emotion in parent's ability to process the information provided and their overall satisfaction of the healthcare provided.—In particularOverall, research indicates that parental satisfaction with their child's healthcare will be positively correlated with perceived interpersonal sensitivity of their providerhysician; but this claim needs further testing. Therefore, the following hypotheses are proffered:

H1: Perceived empathy of the provider hysician will be positively correlated with the provider hysician's perceived credibility.

H2: Parental satisfaction with the communication of bad news will be positively correlated with perceived empathy of their provider hysician.

Method

Participants

The population of interest were parents who have a child under the age of 18-105. A convenience sample will be recruited via a snowball technique. The solicitation message will requested participation from parents who have a child that was diagnosed uatchildren_under the age of ten or under the age of eighteen five and who have received any type of information they would classify as "bad news" about their child from their care provider. The researcher hopes to recruit at least 350 participants will be recruited to complete the study. The survey asked will ask demographics such as their age, race, ethnicity, number of children, income, and educational background.

Procedures

The study was will be conducted via an online survey through Qualtrics. The survey link was ill be sent out to parental organizations that focus on irreversible medical conditions childhood disabilitiesa and illnesses in this area with a request for participation in the survey.

The survey link was will also be posted on social media with a request for participation.

Participants were will first be asked to click on the survey link and provide consent to participate in the study. They were will then be asked to recall the doctor's visit when they were first given a diagnosis of "bad news" about their child's condition. Bad news was will be defined as information that is unpleasant or negatively perceived. The participants were will then be asked to recall how the provider spoketalked and behaved during that conversation by responding to scales that measure provider empathy, provider credibility, and patient satisfaction.

This hey will theasn be followed by a asked a series of questions about their demographics and information about their child's age and health status as well as the provider's medical title (psychologist, pediatrician, etc.) s. They will then be asked to recall the doctor's visit when they

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were first given bad news about their child's condition. Bad news will be defined as information that is unpleasant or negatively perceived. They will then be asked to recall how the physician talked and behaved during that conversation by responding to scales that measure physician empathy and physician credibility. Finally, they were asked to indicate their overall satisfaction with the provider hysician's delivery of bad news by leaving a comment.s.

Thereafter, parents will be thanked for their time and participation.

Instrumentation

Perceived Empathy

Perceived empathy of providers to parents. Perceived empathy wasill be measured using a 5-item, 7-point Likert scale previously used in the Jefferson Scale of Patient Perceptions of Physician Empathy (Hojat, 2010). One signifies strong disagreement. Participants warere asked to indicate their feelings, emotions and concerns; how well they understoomd; the level of concern from the doctor, and if the doctor couldan view the person's perspective.

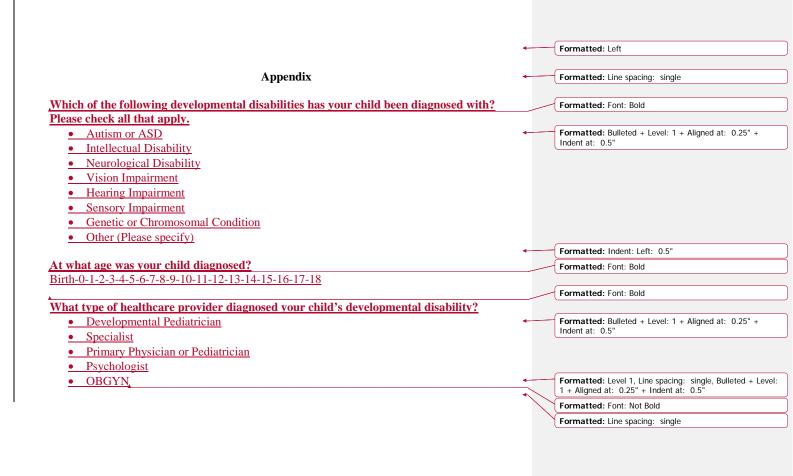
Perceived Credibility

Perceived credibility of providers to parents. Perceptions of credibility will be measured by the generalized belief scale (Paulsel, 2006). This is a 6-item, 7-point Likert scale where 7 indicated strong agreement. Participants are asked to indicate the assertiveness, responsiveness, immediacy, competence, care level, and how confidential they feel their providerhysician is.

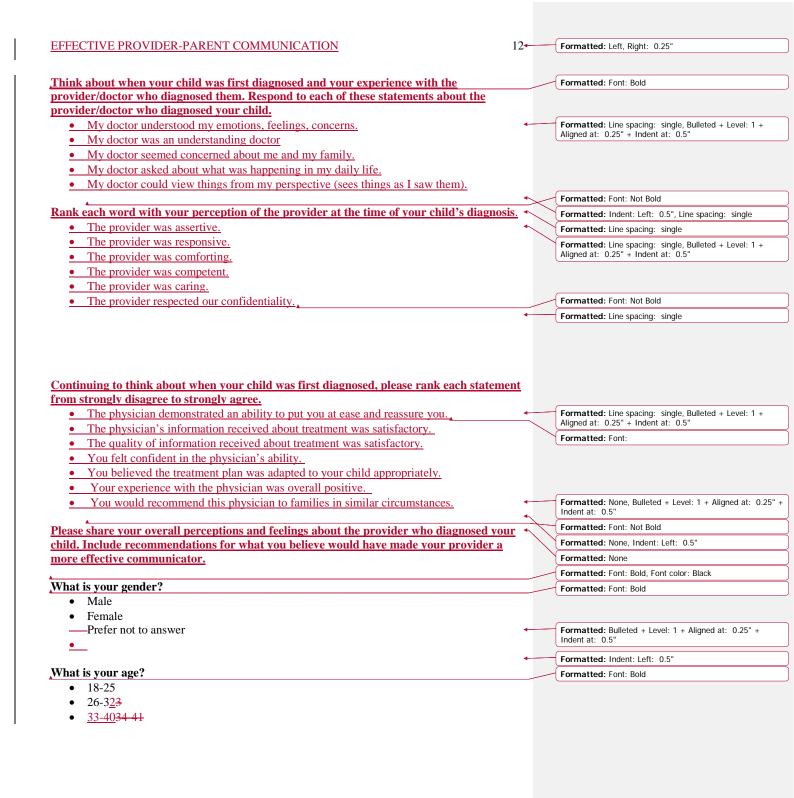
Patient Satisfaction.

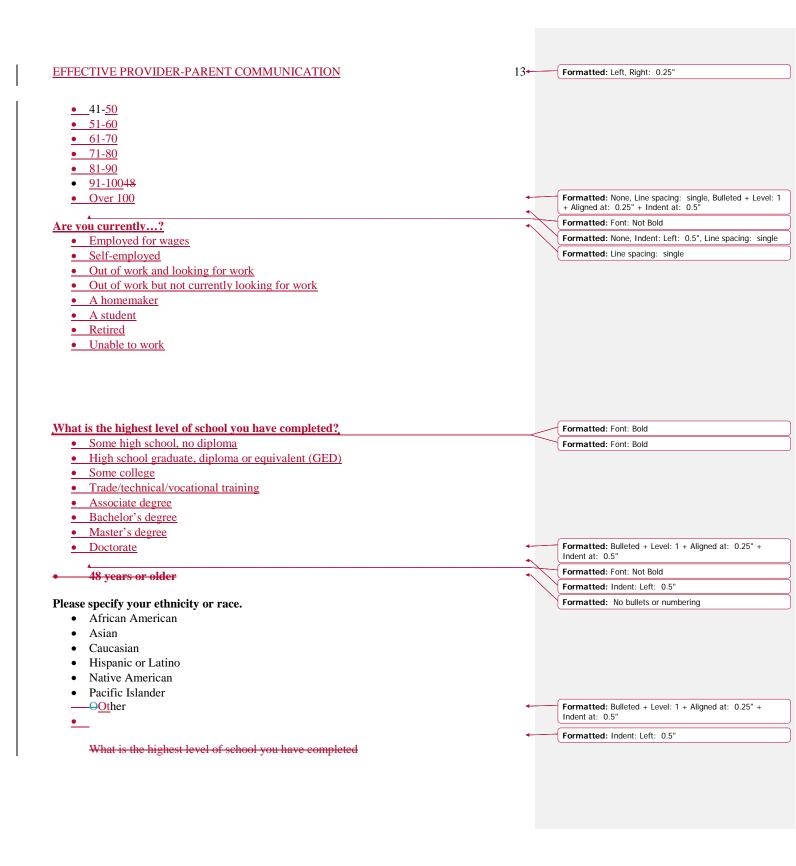
Patient satisfaction was measured with a 7 item, 7-point Likert scale, where 1 indicated strong disagreement and 7 indicated strong agreement. Participants were asked to respond to

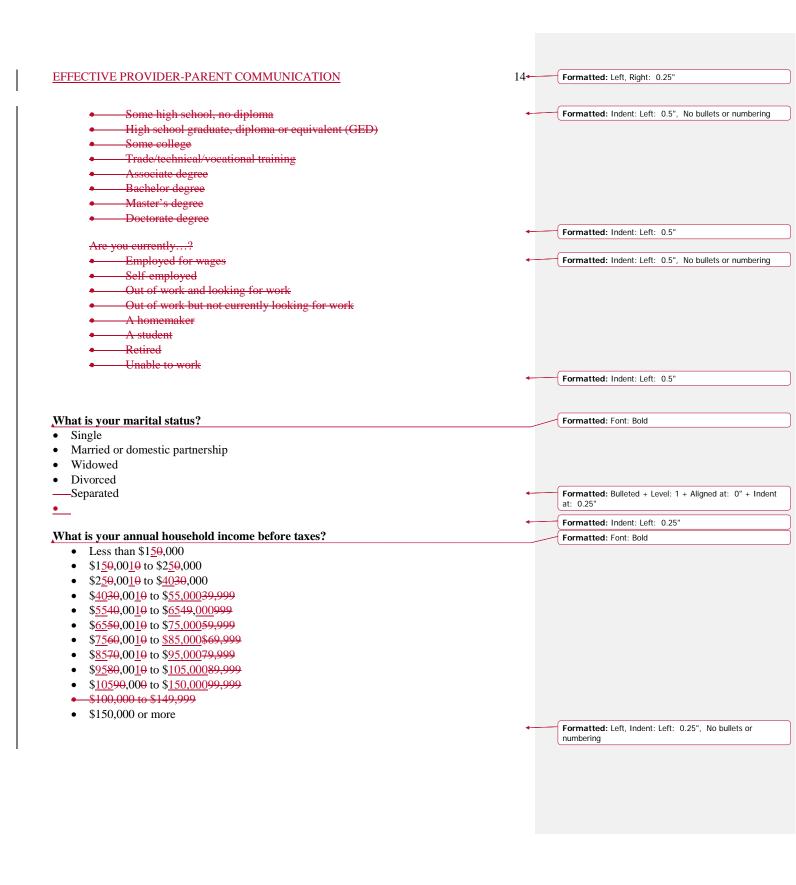
questions about the ability of the proivderproviderphysician to reassure them, the providerphysician's ability to explain the treatment, the quality of the information received, the feeling of security during the appointment, the extent of which the treatment plan was tailored to the child, the treatment overall, and their willingness to recommend the providerhysician to families in similar circumstances. Parent's then will be given the opportunity to write in any additional comments about their feelings on the journey to diagnosis.



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Results

The first hypothesis predicted that perceived empathy of the provider would be positively \leftarrow correlated with the provider's perceived credibility. Results of the bivariate correlation test indicated that empathy was significantly and positively correlated with credibility, r(33) = .73, $p \le .001$. Hypothesis 1 was confirmed.

The second hypothesis predicted that parental satisfaction with the communication of bad news would be positively correlated with perceived empathy of the provider. Results of the bivariate correlation test indicated that parental satisfaction was significantly and positively correlated with empathy, r(30) = .697, p < .001. Hypothesis 2 was confirmed.

Further analysis of the variables in this study and the comments provided by the parents yielded some unexpected and interesting findings. Comment of the parents showed multiple parent's felt more secure with their pediatrician diagnosing their child even though they are not trained to do diagnostics of developmental disabilities.

Perceived Empathy

Rank each statement from 1-7, 1 being strongly disagree, 7 being strongly agree.

- 1. My doctor understands my emotions, feelings, concerns.
- 2. My doctor is an understanding doctor
- 3. My doctor seems concerned about me and my family.
- 4. My doctor asks about what is happening in my daily life.

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5. My doctor can view things from my perspective (sees things as I see them).	
Perceived Credibility	
Rank each word with your perception of the provider with 1 being strongly disagree to 7	Formatted: Font: Bold
being strongly agree.	
1. Assertiveness	
2. Responsiveness	
3. Immediacy	
4. Competence	
5. Caring	
6. Confidentiality	
Satisfaction	
Rank each statement 1-7, 1 being strongly disagree to 7 being strongly agree:	
1. The physician demonstrated an ability to put you at ease and reassure you.	
2. The physician's explanations about treatment were satisfactory.	
3. The quality of information received about treatment was satisfactory.	
4. You felt confident in the physician's ability.	
5. You believed the treatment plan was adapted to your child appropriately.	
6. Your experience with the physician was overall positive.	
7. You would recommend this physician to families in similar circumstances.	
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Introduction/Rationale Section Report contains a clear statement of purpose that identifies the specific area of research literature that will be reviewed. Reasoning and evidence provided for examining the problem. Literature Review The research referenced is complete and well suited to address the stated purpose of the research project. The author effectively extracted relevant data from the study's findings, organized it, and related it to the specific purpose of the research report. A minimum of 10 peer reviewed sources
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the research report. A minimum of 10 peer-reviewed sources
are cited (other types of sources are also encouraged).
Hypotheses or Research Questions 20
At least two high quality research questions or hypotheses
are proposed. (10 points per hypotheses or RQ)
Sample Section 10
Population and how you will sample are explicitly stated.
Human subjects or the artifacts being sampled for this study
are explicitly discussed. Criteria for inclusion are mentioned.
A minimum number of people/artifacts is mentioned and a
justification is provided. Characteristics relevant to the
sample that will be measured are also listed.
Procedures Section 10
The methodology is explicitly mentioned. Step-by-step
instructions of how the study will operate are written out. I
could replicate your study by reading through this section.
Instrumentation Section 20
All the measures for the study each have their own
paragraph description. There is an explicit explanation of
mention how everything will be measured. Sources for
measures are internally cited.
Measures in the Appendix 25
All of the measures are included in the appendix. You will
either create a codebook, survey, or experimental induction
with a questionnaire.

Citations & References	10	
Everything cited within the report is provided in the		
references section. You have a minimum of 10 PEER		
REVIEWED JOURNAL ARTICLES CITED. You will lose -1 point		
for each reference not cited.		
APA Style & Formatting	10	
The proposal follows APA format. A title page and abstract		
are included. The page formatting is precise. The references		
are correctly cited within the text and in the references		
section.		
<u>Professionalism</u>	10	
The writing demonstrates that close attention was given to		
the accuracy and clarity of the proposal. It is free of typos		
and grammatically correct. The writing is clear and precise.		
Optional Writing Center Credit (15 points)		
Your proposal's final grade can be increased by 10% (15		
points) with documentation that proves you had a Writing		
Center consultation about the proposal between 11/30 and		
12/7. Please include documentation at the end of the		
proposal.		
TOTAL	150	