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ORIGINAL RESEARCH

Exploring Nursing and Medical Students' Experiences of Handling Challenging Conversations: A Qualitative Focus Group Study

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Background: Handling challenging conversations remains a major challenge for both undergraduate and qualified nurses and medical doctors. However, challenging conversations are inevitable in daily patient-clinician encounters in clinical and care settings.

Aim: To explore nursing and medical students' experiences in handling challenging conversations with patients and their families.

Setting and Participants: The study was conducted among final-year undergraduate nursing and medical students selected from seven nursing and medical training schools and universities in Southwest, Midwest and Central Uganda.

Design and Methods: This was an exploratory qualitative study. Purposive and convenience sampling were used to select training schools/universities and participants respectively. Data were collected between November 2022 and February 2023 through 10 face-to-face audio-recorded focus group interviews and were analyzed using inductive thematic analysis.

Results: 82 nursing and medical students participated in the study. The analysis yielded four major themes: (1) Students' understanding of bad news, (2) Emotional labor of handling challenging conversations, (3) Handling challenging conversations a theory but not a practice experience, (4) Sociocultural and medico-cultural dilemmas.

Conclusion: The study revealed that participants possessed limited theoretical knowledge, preparedness, and a significant unwillingness to engage in challenging conversations, particularly when communicating bad news or handling conversations related to death and dying. These issues are closely linked to inadequate training and particularly limited or deficient clinical exposure. Simulation-based learning and exposure to challenging conversations are required in clinical settings.

Keywords: bad news, communication, difficult conversations, medical, nursing, student

Background

Communication is a key component of patient-clinician interactions, particularly in the delivery of person-centered care.[1] Person-centered communication views people as a whole (holism) as individuals and with respect. It seeks to empower patients to express their individual needs, values, and choices, as well as their concerns, and empowers them to make informed decisions about their health care.[1–5] Research further shows that patients desire person-centred communication that is not only clear, adequate, and transparent to facilitate understanding, autonomy, respect, collaboration, honesty, support, and commitment,[6,7] but also that it is delivered with compassion.[8,9]

A large body of evidence indicates that the need for good communication is not well appreciated by clinicians, and communication is poor in many patient–clinician consultations.[10] Furthermore, evidence shows poor or inadequate communication during clinical consultations has myriad negative consequences, including perpetuating psychosocial morbidity, compromising self-management of symptoms, causing misunderstanding of a new diagnosis, undermining shared decision making, and diluting patients' overall quality-of-life.[11,12] Deficits in effective person-centred patient-clinician communication remain a major concern for patients.[1,13–16]

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It is evident that handling challenging conversations, particularly about death and dying is hard for both senior and novice health professionals, including students. The inevitability of students and qualified health professionals encountering challenging conversations is well recognized in clinical and care settings.[17–19] This may be related to handling such tasks as delivering bad news about a diagnosis of a life-limiting illness or communicating to the patient and their family the incurability of advanced cancer. Sadly, challenges in handling challenging conversations including but not limited to breaking bad news is a widespread phenomenon prevalent among qualified health professionals.[1,20–22]

This demands that future nurses and doctors be adequately prepared to handle these tasks, including developing positive attitudes, professional skills, and confidence to engage in challenging conversations with patients and their families.[19,23] This will ensure that they do not harm their patients through poor communication. Research conducted with nursing and medical students shows that many lack communication skills and the confidence to engage in challenging conversations with patients and their families.[24–26] As a result, this causes them emotional suffering.[25] A systematic review and qualitative meta-synthesis found a lack of ability in performing nursing skills, particularly communicating with dying patients, by new graduate nurses has profound negative consequences on their ability to maintain intimate relationships with patients and their family members, which hinders the delivery of good quality person-centered care.[27] The review suggested education about death issues should be offered as a core part of undergraduate nursing education programs.

Numerous studies, including those from high-income countries, have demonstrated palliative care training orientates and improves students' knowledge and attitudes necessary for the delivery of high-quality palliative and end-of-life care.[28–30] However, the role and impact of palliative care education and training in influencing students' abilities to handle challenging conversations has been sparsely studied and understood, particularly in low- and middle-income countries. Notably, a systematic review that underpinned this study did not find any documented research in Uganda that has examined this important topic. This is despite palliative care being a taught and examinable course in the curricula for all undergraduate nursing, clinical officers (physicians' assistants), and medical students for almost ten years.

Against this background, this study sought to examine final-year undergraduate nursing and medical students' experiences of handling challenging conversations. This study might generate critical evidence on how their courses prepare future nurses and medical doctors for this important task. In turn, the findings could inform discussions about critical areas for improvement and optimization of learning outcomes, in particular consolidating the knowledge, skills, and appropriate attitudes and their application in the delivery of person-centred care.

Aim of the Study

To explore nursing and medical students' experiences in handling challenging conversations with patients and their families.

Methods

Design and Population

This study employed an exploratory qualitative design using focus group interviews to examine the experiences of nursing and medical students in the final year of their academic program at seven public and private tertiary nursing and medical training schools and universities in Uganda. The study was part of a larger qualitative study that examined 'Final-year undergraduate nursing and medical students' knowledge and perception of, orientation and perceived self-efficacy to provide palliative and end- of-life care'.[31] Table 1 shows the participating nursing and medical schools, and universities.

In Uganda, medical trainees complete one year of internships in a clinical setting under the supervision of seniors and specialists after completing university studies. Prior to the one-year internship, trainees commenced clinical clerkships (also known as clinical rotations) in the third year of their training program, during which they worked with patients in real-life clinical settings under the supervision of their tutors or qualified health professionals.

The diploma-level participants were nursing students in the final semester of a two-year program. These are nurses and midwives who have initially obtained a two-and-a-half-year certificate in nursing and midwifery and have been in practice for at least two years. The certificate-level participants were nurses in their final semester of a pre-registration two-and-a-half-year certificate in the nursing and midwifery courses. These students joined their nursing school after

Table 1 Showing Participants' Schools/Universities of Affiliation

	Institution/University	Founding Body/ Ownership	Region	Participants' Course of Study
1.	Kampala International University-Western Campus	Private	Southwest	Certificate in nursing, Bachelor of Science in Nursing
2.	Mbarara University of Science and Technology	Government/public	Southwest	Degree in Medicine and Surgery
3.	Makerere University	Government	Central	Degree in Medicine and Surgery, Bachelor of Science in Nursing
4.	Uganda Christian University	Anglican Church founded	Central	Degree in Medicine and Surgery
5.	Mulago School of Nursing and Midwifery	Government/public	Central	Diploma in midwifery
6.	Hoima School of Nursing and Midwifery	Government	Midwest	Certificate in nursing and midwifery
7.	Ishaka Adventist School of Nursing and Midwifery	Seventh Day Adventist Church	Southwest	Certificate in nursing and midwifery

secondary level 4 (Uganda certificate of education), whereas very few joined after advanced secondary level 6 (Uganda Advanced Certificate of Education).

Communication skills are taught and examined in the curriculum for undergraduate nursing and medical students in Uganda. Furthermore, the students were again exposed to communication skills in the palliative care course, where they were taught how to handle challenging conversations and/or bad news in clinical and care settings.

Recruitment Procedures

Purposive sampling was used to select three nursing schools and four universities in three of the five main regions of Uganda. In addition, the sampling ensured good representation of levels and courses of study, that is final-year certificate, diploma and degree nursing students, and final-year medical students. Access to eligible participants was gained through their respective department heads or deans following ethical and institutional approval. Convenience sampling was employed to recruit participants because of the nature of their setting. In other words, participants were enrolled in the study based on their accessibility, availability, and willingness to participate.

Students were eligible for enrolment in the study if they (i) were in the final year of their undergraduate nursing or medical program, (ii) were Ugandan, and (iii) provided voluntary written informed consent.

Data Collection Procedures and Tools

Data were collected through face-to-face audio-recorded focus-group interviews using an open-ended topic guide developed by the research team. A pilot study was conducted with two focus groups comprising (nine and eight respectively) certificate-level nursing students in their final year, to assess the comprehensiveness, relevance, and reliability of the topic guide in gathering information suitable for the aims of the study. Pilot studies are known to increase research quality.[32,33] No significant modifications were required following the pilot; hence, the results were adapted and analyzed together with data from subsequent interviews.

The data were collected between November 2022 and February 2023. Focus group interviews were conducted by the corresponding author (GN) who has experience conducting qualitative interviews with patients (particularly with palliative care needs) and health professionals. Note taking was performed by trained research assistants and GN. GN was a student pursuing a Master of Science degree in Palliative Care at the time. Focus group interviews were conducted in English in quiet places on dates and times convenient for the participants. All but one (held in a student hostel room) were conducted in lecture rooms at each of the participating schools/universities.

Given the qualitative nature of the study, data analysis commenced simultaneously with the data collection. At the 8th interview, the analysis revealed no new emerging themes. This was true for the 9th and 10th interviews. At this point, it was confirmed that data saturation had been reached, and data collection was suspended. Interviews lasted between 37 minutes and one hour and 18 minutes, with a mean duration of one hour (see Table 2). The length of the interviews was related to the level of engagement of the group and their experience in dealing with breaking bad news. Group 6, see Table 2, were close to some final exams and did not engage with the process as much as other groups.

Data Analysis

The analysis was underpinned by inductive thematic analysis as proposed by Virginia Braun and Victoria Clarke.[34] This is a six-step systematic approach to qualitative data analysis: (1) data familiarization - GN first pseudonymized the interviews, frequently listened to the audio-recordings, transcribed the recordings verbatim, thoroughly scrutinized field notes, read and re-read the transcripts while gaining familiarity with the content, scope and diversity of the data. (2) generating initial codes-indexing by assigning codes to segments of the transcripts using colored highlighters in Microsoft Word, (3) searching for emerging themes-critically read and re-read the emergent codes while aiming to group together statements and codes and categories that reflected homogeneity or similarities in meaning to generate broad-based themes, (4) reviewing themes-initial emergent themes were further critically reviewed for confirmation, during which appropriate amendments and movements were done to enrich clarity, (5) defining, refining and naming themes-including naming main themes and corresponding subthemes and assigning verbatim quotes that related to the (sub) themes and (6) writing up the report - a succinct synthesis and writing up of a narrative report.

The corresponding author (GN) initially coded transcripts. He then independently shared the transcripts and initial reports with the second and third authors (PE) and EN who are senior researchers with experience in research, teaching,

Table 2 Characteristics of the Focus Group Discussions

Interview Code Number	Participant's School/ University Code	Participants' Course of Study	Number of Focus Group Participants	Duration of Interview
Focus group 1	A	Certificate in nursing and midwifery	9	57 minutes
Focus group 2	A	Certificate in nursing and midwifery	8	50 minutes
Focus group 3	B	Certificate in nursing and midwifery	8	1 hour 14 minutes
Focus group 4	C	Degree in nursing	4	49 minutes
Focus group 5	D	Degree in nursing	8	51 minutes
Focus group 6	E	Diploma in midwifery	10	37 minutes
Focus group 7	D	Degree in medicine and surgery	13	1 hour 6 minutes
Focus group 8	F	Degree in medicine and surgery	6	1 hour 10 minutes
Focus group 9	G	Certificate in nursing and midwifery	10	1 hour 9 minutes
Focus group 10	H	Degree in medicine and surgery	6	1 hour 18 minutes
Total number of FGD participants			**82**	

and publication. They returned their comments, including disagreements and suggestions which were discussed in a series of regular meetings held on Zoom, via WhatsApp and Email until consensus was reached. Decisions on the final sub (themes) and verbatim quotes to include in the report were reached by consensus.

Trustworthiness and Rigor

A pilot study was conducted with two focus groups comprising 17 eligible final-year certificate-level nursing students to refine the topic guide and to confirm its *reliability and validity* for the aims of the study. This enhanced the clarity of the guide and reliability of the findings. To ensure *confirmability* of the findings, member-checking was performed by returning transcripts to three focus groups (medical students). The feedback indicated that the findings were a true reflection of the information shared during the focus group interviews. The sample size was determined using the saturation principle. This ensured a sufficiently thick and in-depth exploration of the topic, further enhancing its trustworthiness. Participants were selected from different schools and courses (certificate, diploma, degree) which ensured multiple dimensionalities of views and, to some degree, the representativeness of the study.

The analysis, development, and reporting of themes are supported by participants' verbatim quotes and a visual logical schematic summarizing participants' excerpts and emerging categories and themes adds to the transparency and auditability, and hence, the credibility of the findings.

The study was conducted and reported according to the Consolidated Criteria for Reporting Qualitative studies (COREQ)[35], further increasing the overall robustness of the study.

Results

Participants (n=82) were age range 20–39 years with a mean age 24.36±3.29 years. The majority (90%) were in the age range 20–29 years.

Themes

Four master themes emerged (Figure 1): (1) students' understanding of bad news; (2) emotional labor associated with handling challenging conversations; (3) handling challenging conversations, a theory but not a practice experience; and (4) sociocultural and medico-cultural dilemmas.

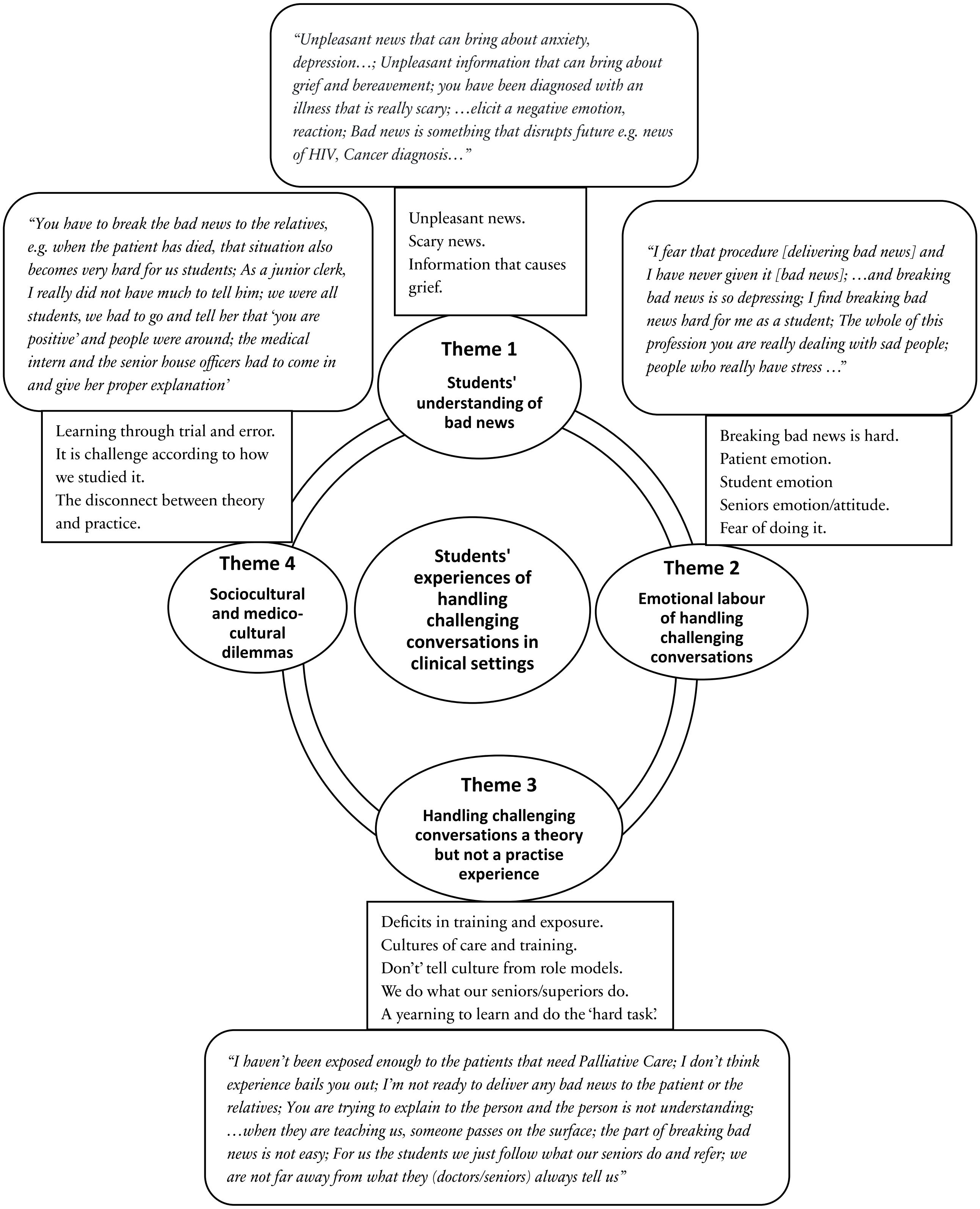
Additional excerpts supporting emergent (sub) themes are provided in Supplementary file 1.

Theme 1: Students' Understanding of Bad News

The participants discussed their understanding of bad news. There was uniform recognition across all focus groups, that breaking bad news was a common subset of "difficult" or challenging conversations in palliative care. They defined bad news using descriptors such as "news that patients don't want to hear, news that causes grief, news that elicits negative emotion, reaction, heartbreaking news…" and cited examples of such news, breaking the news of a diagnosis of an incurable disease, such as cancer and HIV/AIDS, being the most frequently mentioned examples:

[Abbreviations: ECN: Certificate in Nursing, Dip-N: Diploma in Nursing, BSN: Bachelor of Science in Nursing MB ChB: Bachelor of Medicine and Bachelor of Surgery]

> Bad news is unpleasant information that can trigger negative emotional response; anger, stress e.g. a lab test that turns out positive for cancer, Sickle cell disease, HIV, Diabetes, TB [Tuberculosis]. ECN, FGD 2
>
> Bad news is information you convey to the patient that may change or shift one's mood, or be so heartbreaking… your patient has died, or you have HIV, or you have been diagnosed with an illness that is really scary. BSN, FGD 5
>
> Bad news is information that you are giving either to the patient or caretakers that is going to elicit a negative emotion, reaction, all that. Eg someone having a terminal illness which is in its late stages, telling them the amount of time they are left with to live [all agree]. MB ChB, FGD



“Unpleasant news that can bring about anxiety, depression…; Unpleasant information that can bring about grief and bereavement; you have been diagnosed with an illness that is really scary; …elicit a negative emotion, reaction; Bad news is something that disrupts future e.g. news of HIV, Cancer diagnosis…”

Unpleasant news.
Scary news.
Information that causes grief.

“You have to break the bad news to the relatives, e.g. when the patient has died, that situation also becomes very hard for us students; As a junior clerk, I really did not have much to tell him; we were all students, we had to go and tell her that ‘you are positive’ and people were around; the medical intern and the senior house officers had to come in and give her proper explanation’

Learning through trial and error.
It is challenge according to how we studied it.
The disconnect between theory and practice.

“I fear that procedure [delivering bad news] and I have never given it [bad news]; …and breaking bad news is so depressing; I find breaking bad news hard for me as a student; The whole of this profession you are really dealing with sad people; people who really have stress …”

Breaking bad news is hard.
Patient emotion.
Student emotion
Seniors emotion/attitude.
Fear of doing it.

Deficits in training and exposure.
Cultures of care and training.
Don’t’ tell culture from role models.
We do what our seniors/superiors do.
A yearning to learn and do the ‘hard task’.

“I haven’t been exposed enough to the patients that need Palliative Care; I don’t think experience bails you out; I’m not ready to deliver any bad news to the patient or the relatives; You are trying to explain to the person and the person is not understanding; …when they are teaching us, someone passes on the surface; the part of breaking bad news is not easy; For us the students we just follow what our seniors do and refer; we are not far away from what they (doctors/seniors) always tell us”

Figure 1 Emergent themes and subthemes.

Theme 2: Emotional Labor of Handling Challenging Conversations

Subtheme 2.1: Handling Challenging Clinical Scenarios and Conversations Is a Hard Task

Participants discussed the difficulties related to handling challenging clinical scenarios encountered in clinical settings in their interactions with patients, caregivers, and fellow health professionals. Breaking bad news (BBN) was the most common theme reported by nearly all the participants in this study and emerged in four sub-themes: experiences with BBN, attitudes and perceptions toward BBN, self-efficacy in handling challenging [“difficult”] situations, and lessons learned from BBN experiences. They used descriptors such as ‘hard’, ‘very hard’, “difficult”, and “very difficult” as they discussed what they felt about and had experienced when handling the task. Nearly all referenced BBN was the hardest part of the entire palliative care course, and so they disliked it:

> The course was not so hard; but the problem came in the last topics where you have to break the bad news to the relatives, e.g. when the patient has died, that situation also becomes very hard for us students. ECN, MP6, FGD 2

> It [working with patients with life-limiting illness] is always about breaking bad news, aahh, No, No and breaking bad news is depressing, and the way they [patients] react; if it was that they react the same way, you’d get used to that, but different people react differently, so having to deal with all their tantrums and everything. MB ChB, FP6, FGD 8

> Breaking bad news is hard for everyone. It’s very hard especially when you know the person and the person you have been interacting with, it is very hard. It’s something, I think that needs more training but it is hard and as doctors it is like a nightmare. … it is a lot to deal with. I don’t know if someone can be trained to do that, but it is too much. MB ChB FGD 10

Subtheme 2.2: Students’ Attitudes and Perceived Self-Efficacy in Handling Challenging Conversations

The majority held negative attitudes towards handling challenging tasks, particularly BBN. They expressed fear and anxiety and how they felt unprepared or inadequately prepared, lacked the necessary confidence, were unwilling to work with patients with life-threatening and life-limiting illnesses, and handle challenging [“difficult”] tasks:

> Sometimes, I am like, how will that patient react to me? How will he take this information that I’m giving sometimes you find if the patient is your relative…breaking bad news is not easy. ECN, MP4, FGD 3

> We have been trained, we did communication skills, we did Palliative care, and also, we talked about it [BBN] in medical ethics and forensic medicine but…. I would definitely first walk around to get some confidence. Eeh, that is even if I can manage to tell them coz, I remember being sent to go and call the caretakers so that they could tell them together and I was shaking all over…. eeh, I can imagine being in those shoes is not easy. I may be heart broken, I may even cry afterwards. MB ChB, FGD 7

> I am not ready to deliver any bad news to a patient or their relatives; because, personally, I am very empathetic. I don’t think experience bails you out. It’s about you detaching your emotions from the patient, which is not something you learn overnight. MB ChB, FP4, FGD 8

> First of all, you are fearing their [patients’]reaction, what will their reaction be like? Coz, people react differently. ECN, FP1, FGD 9

Very few (from one focus group conducted with medical students) narrated how they liked learning about BBN and recognized it as a crucial task every clinician should master. It is likely their perceptions were influenced by the training they received, particularly during palliative care course module:

> The ones I liked were breaking bad news coz I think it’s very relevant to us as medical doctors. MB ChB, MP5, FGD 8

> I don’t remember disliking any particular topic. I think palliative care generally is a good course. The ones [topics] I liked most; we learnt about breaking bad news and the four stages of grief. I enjoyed learning about that psychology. MB ChB, MP, FGD 8

Theme 3: Challenging Conversations, a Theory but Not a Practice Experience

Subtheme 3.1: Cultures of Care and Training

Inadequate training or clinical exposure was a central theme that permeated all the other themes. The students criticized and blamed their challenges in handling challenging tasks, including their inability and unpreparedness to deliver palliative and end-of-life care, on the inadequate training which they said was largely theoretical with very limited/virtually no opportunities for them to acquire necessary competencies, which evidently manifested as misinformation regarding how to approach challenging conversations:

> I have ever given bad news of HIV but cancer I've never [none has ever worked with cancer patients]. ECN, FP2, FGD 1
>
> When they are teaching us, someone passes on the surface bit, they will not go into the details about how you are going to handle this patient's condition [inadequate training]. The course was taught for a semester. ECN, FGD 3.
>
> For us we work with patients with HIV, but here at our school, they take care of cancer patients. We have not had a chance to be taken to the cancer institute, it has not happened, … FGD 6, Diploma midwives
>
> We spent one week on ward, but the lectures were for a whole semester, but the interactions with patients was one week, actually it could even be less than three days. MB ChB, MP1, FGD 7

Very few students demonstrated good comprehension and theoretical knowledge of handling challenging conversations [frequently referred to as "difficult conversations" by the students]:

> I would prepare where I am to break the bad news from. Of course, breaking bad news needs privacy, then I first see what the patient needs to know and what she knows about her condition. After that, I tell her the information. As I tell the information, I observe for the reaction and manage accordingly. Coz, sometimes, we need to leave these patients to go into the process. If the patient is crying, you leave them to cry, then later, slowly, she will pick up and follow up and when you are giving bad news, you have to look into the patient's face, not looking the other side. Before the patient leaves your way, you really need to know what this patient is thinking about… ECN, FP3, FGD 3

Subtheme 3.2: We Do What Our Seniors Do

This was another central theme that fed into nearly all the other themes. Students discussed the cultures of care and training, citing the barriers that prevent them from learning and acquiring knowledge, skills, and appropriate attitudes towards handling BBN. They cited the "don't tell" culture from role models, where seniors choose to shy away and hide bad news from patients and/or their caregivers and coach them [students] to do the same:

> If you critically listen into what comes out of them [doctors, seniors], we are not far away from what they always tell us…ECN, MP5, FGD 3
>
> Also, on ward, we don't actually do the palliative care, we just refer. For us students we just follow what our seniors do and refer. Referring may not be something bad coz you are referring to people [Hospice] who have studied more but now that means, as students, we won't learn. MB ChB, FGD 10

Few of their narrations featured positive learning experiences encountered in clinical and care settings. Very few had the opportunity to experience and learn alongside qualified health professionals or tutors/lecturers:

> My senior was trying to explain to this young lady; she was pregnant. She had come for her first antenatal visit. They tested her and 'sister' [senior nurse] realized she was HIV positive. She tried to explain to her to prepare her for the news, she broke the news to her, but the lady was not accepting. My senior called me, who is junior, to go and also help in explaining to the lady. We had to test the lady again and the results were positive. Now, we two, a senior and a junior had to combine, and we broke the news to the lady and the lady had to accept. ECN, MP4, FGD 9
>
> I was lucky to see an anesthetist at some hospital deliver bad news. I picked something small. He tried to deliver this bad news to these ladies and later on they broke down. MB ChB, MP1, FGD 10

Subtheme 3.3: A Yearning to Learn and Do the Hard Task

Some participants acknowledged that, despite handling challenging conversations being a hard undertaking, they felt that it could be learned. They, mostly medical students, expressed a yearning to learn how to handle challenging conversations because it is an inevitable part of their job role:

> I would just watch seniors perform. Then, even when you try to ask, they say first wait. So, sometimes the students are denied chance to actively participate in providing palliative care. ECN, MP7, FGD 1

> At least it [palliative care] has given us something better. These things need to be done in practice; Mere reading is not enough. So, it would be better if we are able to practice what we have covered in class, which may not be possible because most facilities do not have palliative care. So, getting in contact with patients and applying knowledge is really hard. BSN, FGD 4

> These things need to be done in practice, Mere theory is not enough. We learnt palliative care once a week for one semester and we had a few days of going on ward; the cancer, oncology ward to be taught what we learnt in the lecture. Every group went about three times. That time was good. Actually, we studied a lot but didn't get time to practice all of it. The three times on ward of just one hour each may not really be enough. May be if we had time to go there and learn all the principles. Now, like breaking bad news, we were taught breaking bad news, but you reach there when the news has already been broken. We just have the theory. MB ChB, FGD 10

Theme 4: Cultural and Medico-Cultural Dilemmas

Subtheme 4.1: Learning Through Trial-and-Error

Participants narrated how, despite a lack of knowledge, skills, and mentoring in handling challenging conversations, they are inevitably confronted with scenarios in clinical settings where they must perform the task. This perpetuates the emotional labor associated with this role. Nearly all recounted how, in clinical settings, qualified professionals (their seniors/lecturers) shy away or shun challenging conversations, and instead delegate tasks to them. Because they are not being coached on how to handle the task, they end up doing it so badly which can have devastating effects on both the communicator and the receiver:

> I have never given bad news here in the pediatric department. The bad news was just telling the mother of the child that her child had been diagnosed with sickle cell disease. I accepted to give them that report coz according to me, at that time, it was not a big issue, but once I told the mother about the confirmed diagnosis, she just broke down and she started talking about whether the cause is the child's father and all that. So, after delivering the bad news, and because of the chaos that erupted, the medical intern and the other fellow senior house officers (SHOs) had to come in and give her proper explanation. MB ChB, MP6, FGD 7.

> I broke bad news to a patient who had contracted HIV. A health worker came and tested her. After, she gave us the results. Of course, we were all students, we had to go and tell her that 'you are positive' and people were around her and even the family members who were there had to listen, but the patient did not want the family to know because she had cheated on her husband and had contracted the HIV from another man. We did not know how to break bad news by then. After being depressed, that patient refused food. ECN, FP, FGD 9.

> I remember one of the first days of internal medicine, on medical ward, we were doing a ward round and there was a lady. She was elderly and she was on oxygen and as we were doing the round, she passed on. So that time I was in 3rd year. This senior doctor just requests me to tell the caregiver that the person has actually passed on. So, I just translated and I was like yeah,your grandmother has died. We did not do anything. I just went and told this person [bereaved caregiver] and the ward round was actually still going and we proceeded. But later, I realized that [breaking news of death to the patient's family badly] was so wrong. Maybe we could have done better after giving the news. So, I learnt we did a mistake from that one person. I don't know if this was right. I don't know what I should have done. MB ChB, MP1, FGD 10

Only two students discussed an awareness that it was okay not to have answers all of the time. In such situations, when challenged, they practice honesty and seek support from seniors who know better rather than forcing it and get negative repercussions:

> We are still students, we are on the lower end of the pedigree, and we are not allowed to give definitive decisions and outcomes to the patients. Just one scenario but, it was not in a setting of palliative care. A mother had lost a pregnancy and she had come in an emergency thinking they might save the pregnancy or it's a smaller problem but actually she had lost the pregnancy and previously, a year ago she had lost a newborn. The husband asked me whether their pregnancy was going to survive but since I was not the one on top of the care team, I could not give it to them definitely that this is what has happened. So, I had to call

> my senior who was caring for them, who was on top of the team and making decisions; she's the one who had to tell them that they had lost the pregnancy. But if I was not a student, I'd be the one to give them the bad news. MB ChB, FGD 7

> There is an extent where you reach and feel you can't do it, e.g. an aggressive patient. You are trying to explain to the person and the person is not understanding. For me, I am a junior, I have to forward the patient to or consult with the senior, coz I don't want to force it and something happen. ECN, FP10, FGD 9

The students discussed how handling challenging or "difficult" conversations is a task that requires preparation to be able to do it well. Their understanding of this need was mainly shaped by reflections on the experiences they had handling challenging conversations, in particular, the consequences it had on the patients, their caregivers and on themselves:

> Delivering bad news is never a good experience for anyone, not even the messenger or the receiver. No one takes pleasure in it. But we were taught not to prolong it; it is better to give and explain information to the patients as soon as possible, you have to be honest and address their concerns, take note of their feelings or whatever reactions. MB ChB, MP, FGD 7

> It is not an easy task that you can just do it and throw it in front of the patient given the fact that patients are different, and you can't rehearse it or expect it to be the same for every patient and the support system around them. If you don't understand, you will just throw the news and they [the patient] may react by jumping off the top floor. So, you need to first understand before you break the news. I believe we can't just do it; we need exposure to gain experience. So, it is not as easy as we think. MB ChB, MP, FGD 7

Subtheme 4.2: The Disconnect Between Theory and Practice

They were concerned about the disconnection between the theory they studied in the classroom and the reality they encounter in clinical practice, citing difficulties in applying the theory to clinical scenarios. In other words, translating theory into practice presents a challenge. A few imagined handling challenging conversations was a simple task, whereas others perceived bad news as normal news. Notably, their perceptions were underlined by a lack of exposure and misinformation:

> Those things [palliative care], we studied them but it's as if they are not applicable to our settings. We studied but when we are implementing it, it is a bit tricky [all agree]. ECN, MP6, FGD 3

> First of all, the way they taught it [breaking bad news], it wasn't tying well with what we see in practice. We have steps like how to first get privacy for the patient, I mean, you're there on surgical ward and people are on the floor, there are no beds, where shall we get rooms? You find the doctor is talking to the patient, the caretakers are there, other patients are also there listening, and the whole thing is packed. So, it brings a lot of anxiety. MB ChB, MP5, FGD 10

> Some lady had cancer of the cervix but the caretaker or the sister plus the nurses on ward said we should never tell her that she has cancer of the cervix. That if we told her she would die. I don't know for that case, if I was supposed to wait when they have gone away and I come and tell the patient or it was better to keep quiet! I think it's more of medical ethics than palliative care. MB ChB, FGD 10

Discussion

This study aimed to explore the experiences of nursing and medical students in handling challenging conversations during clinician-patient and student-patient conversations in Uganda. The study identified four major themes: *Students' understanding of bad news, (2) emotional labor associated with handling challenging conversations, (3) Handling challenging conversations a theory but not a practice experience, and (4) Sociocultural and medico-cultural dilemmas.*

To them, delivering bad news to patients, and sometimes their caregivers, is emotionally derailing and energy draining. Those who were already qualified and had been in practice before appeared to have similar challenges in handling the task as did their non-practicing colleagues. Their discussions were punctuated with multiple elements of misinformation, disinterest, and deficits in preparedness to engage in challenging conversations.

Most dislike engaging in challenging conversations related to death and dying. This mirrors the study by Dobrowolska et al[36] who found medical and nursing students prefer to avoid working with dying patients. Evidently, there is an overarching influence of sociocultural and medico cultural factors on their experience which includes pseudo-knowledge, attitudes, and perceived self-efficacy towards challenging conversations. The students revealed how discussions about death and dying are stigmatized by culture, being regarded as taboo in Ugandan culture, and so must be avoided for the sake of not offending or conflicting with the culture.

There is a theme which identifies how no one likes to talk about or break bad news; therefore, it is a delegated task and as such, is seen as a horrible undertaking. Furthermore, the students know little about person-centered cultures of care. Previous research contends that the cultural attitudes of patients' families toward disease and death sometimes inhibit learning and knowledge translation about end-of-life care among nursing students.[37] Yet, talking about death and end-of-life care can have a significant influence on students' attitudes towards challenging conversations and caring for the dying.[38]

There is a theme about suboptimal behavior of supervisors, where those who are qualified (senior doctors and nurses) and should be positive role models and should know better allow others (juniors/novices) to make poor decisions for patients. Students cited that seniors shun or shy away from challenging conversations, particularly discussions about death, dying, and BBN, and delegate such tasks to them. The result is that students undertake these tasks, perform them badly or inadequately, and become vulnerable to emotional distress which is then transmitted to patients. This is a common occurrence for students and perpetuates their fear and dislike for especially palliative care where such challenging scenarios are commonplace.

Furthermore, the students discussed the 'don't tell' paternalistic culture of care and training which is dominant in clinical settings. They said that it is commonly applied by qualified and senior clinicians in situations where they feel or assume that the emotional impact of engaging in challenging conversations is too great for both the patient and health professional. Thus, the safety net becomes "don't tell", because it is considered less harmful. This phenomenon is perpetuated by the assumption that patients and their families do not usually want to hear bad news.

Consequently, students emulate this practice and are coached to apply this protective mechanism when confronted with challenging or "difficult" scenarios. They see palliative care as an irritation/imposition, as something to fear, or something which may impact on their own well-being because they fear witnessing patients' emotions. They fear BBN, ethical dilemmas arising in practice, death, dying and challenging cases such as how to respond to 'hard questions' from patients and family especially giving news about diagnosis of a life-limiting illness, prognosis, and incurability of illness, and in turn the whole experience becomes emotional labor to them.

Emotional distress and professional difficulties are perpetuated by feelings of fear about the reaction of family members, powerlessness, unpreparedness, and uncertainty related to handling challenging conversations, including addressing patients' psychological needs and coping with their own emotions when dealing with challenging conversations, death, and dying - phenomena which have been reported in numerous previous studies conducted with nursing and medical students.[36,39–41] In a study of medical students in Germany, for example, Gerlach et al[42] found that after the 5th and 6th year (practical year), medical students felt they were less competent in engaging in challenging conversations, especially end-of-life conversations, and talking about disease incurability than they had when they were more junior. Other studies have also reported similar findings.[24–26]

The students then criticized the training and preparation they have received. First, it is inadequate, theoretical, and didactic, with limited and sometimes no opportunity for experiential exposure, and so generally does not match the demands of the job. They see a disconnection between what they learned in the classroom and the reality they encounter in practice. In other words, much of what they have learned in the classroom does not sit well with what they see in practice, and this confuses them, perpetuating emotional labor and their dislike of working with people living with life-threatening and life-limiting illnesses, in particular citing palliative care and engaging in challenging conversations. Only two focus group participants showed somewhat positive, but inadequate, attitudes towards and comfort in engaging in challenging conversations with patients.

Inadequate education and training are common issues reported in many other studies.[38,43,44] However, there is sufficient evidence supporting the need for high-quality education and training to improve and consolidate students' understanding of, positive attitudes towards, and self-efficacy to provide good person-centred care, particularly in palliative and end-of-life care settings,[28–30] including improved self-efficacy in communication.[45] In particular, literature supports the integration of simulation-based teaching (using clinical scenarios) to reinforce the learning of favorable attitudes, self-efficacy, and communication skills to manage complex chronic and end-of-life situations.[46–48]

The difficulties of translating good communication skills to the practice setting are not unique to Uganda. Many students learn how to communicate with patients and families from senior colleagues in practice and this can lead to the perpetuation of poor practice and stigmatized speech. One study conducted in Ireland, for example, found that the use of stigmatizing language when communicating with patients was common in hospitals and that the healthcare professionals failed to correct each other when it was used because of desensitization and because they worked in hierarchies.[49] The impact of clinical role models and the realities of practice have been shown in many studies to affect, usually negatively, the development of traits such as empathy[50] and person-centredness[51] in communication among medical students.

Notably, several students mentioned that whereas handling challenging conversations is "difficult" and emotionally demanding, they acknowledge it as an important part of the job; a task their profession obligates them to perform and that it is inevitable They believe that it can be learned and that they have the desire to learn and be empowered to do so. However, there was recognition that handling challenging conversations requires both adequate training and clinical preparation. There is evidence showing that adequate training with opportunities for practical application and skills transfer improves students' knowledge and confidence in handling challenging conversations, notably BBN.[52]

Strengths and Limitations of the Study

This study had several strengths. *First*, to our knowledge, this is the first study to explore the topic in Uganda; hence, the findings are novel in nature, not only in the context of Uganda but possibly in other countries. *Second*, the heterogeneity of views achieved through recruitment of students from different training schools, regions, and courses (certificate, diploma and degree, nursing, and medical) adds reasonable representativeness and confirmability to the findings.

Nonetheless, this study had some limitations. *First*, participants were recruited from only seven training institutions representing three of the five regions in Uganda. Hence, the study may have limited representativeness. Therefore, future research should sample participants from schools that are not included in this study. *Second*, the study did not recruit clinical officers (physician assistants), who are crucial cadre of professionals in Uganda's healthcare system. To date, their views have remained unexplored. Future research should address this gap.

Conclusion

The study identifies numerous negative attitudes and poor orientation towards BBN associated with low self-efficacy or self-confidence and a low, or lack, of preparedness or willingness among health students to engage in challenging conversations with patients. This relates primarily to BBN, including disease incurability and discussions about death and dying. These issues stem from inadequate teaching, training, coaching, and mentoring in the crucial aspects of holistic person-centered care. This inadequacy may also stretch to include the tutors who may lack the skills and experience to train students to BBN. This raises questions about the perpetuation of poor practices and the need for better education and preparation of the educators.

Focus group interviews revealed that teaching and training in communication are mainly theoretical and classroom-based, offering very limited or no opportunity for students to experience learning in real-life clinical settings. Consequently, students either shun or try out challenging (or "difficult" as they, students frequently described them) conversations and tasks on their own without support from those who know better and consequently become vulnerable to the resultant emotional labor. To overcome these deficiencies and remedy the situation, the design and delivery of palliative care course training should integrate both practical and simulation-based scenarios to consolidate learning and allow translation of theory into practice.

The findings of this study suggest that prohibitive paternalistic cultures of care and palliative and clinical care training in Uganda must be addressed. Notably, students would best benefit from role models who can coach and mentor them to embrace challenging conversations as an important part of their roles. A review of palliative care courses and curricula for nurses and medical doctors is crucial for ascertaining their comprehensiveness, especially around BBN.

The skills needed to undertake BBN urgently need developing during the training of health professionals, to reduce the devastating effects on both the communicator and the receiver (usually the patient or their caregiver) of poorly managed communications. Evaluation and longitudinal studies are needed to assess the impact of different approaches to learning and teaching on meeting learners' needs. Likewise, a study assessing the understanding and attitudes of trainers (tutors) is important to understand their viewpoints, as they are likely to impact the delivery of the course and the learning experience of students.

Data Sharing Statement

The data collected and analyzed in this study are reported in this manuscript. The raw dataset findings are available from the corresponding author upon reasonable request: Germanus Natuhwera, gnatuhwera@hospice-africa.org or ngermans16@gmail.com.

Ethics and Informed Consent to Participate and Publish Statement

The protocol for this research was reviewed and ethical approval was obtained from Hospice Africa Uganda Research Ethics Committee (reference *HAU-2022-03-A)*. Approval was granted on 20th September 2022. Administrative clearance was obtained from the Makerere University School of Medicine Research Ethics Committee on 28th October 2022 and again from each participating school or university prior to accessing participants. All participants provided written informed consent for their participation and publication, including publication of anonymized responses/direct quotes. This study complies with the Declaration of Helsinki.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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