ARTICLE

Assessing "Breaking Bad News" Communication Competency in Midwifery Students

by Kathi Wilson, BA, BHSc, MSc (c)

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ABSTRACT

The communication task of conveying difficult news to patients by health care providers, described in the literature as "breaking bad news," is one that is often performed poorly. There is, at the same time, a relatively small amount of research in the health sciences education literature devoted to the assessment of this particular competency. Like other health care providers, registered midwives in Canada are expected to have knowledge and skill in this domain of communication. In the Ontario Midwifery Education Program, senior students are expected to develop competence in managing situations involving loss during the childbearing year; however, there is little guidance for preceptors with respect to the assessment of performance for this skill. This article reviews the relevant literature on the assessment of "breaking bad news" and workplace assessment tools in health education, and proposes the use of a clinical encounter card that uses a modified Breaking Bad News Assessment Scale to assist and guide preceptors. Further investigation of the tool's reliability, validity, and acceptability to preceptors is needed.

KEYWORDS
breaking bad news, midwifery education, performance assessment, workplace-based assessment

This article has been peer reviewed.

Évaluation des habiletés en ce qui concerne « l'annonce de mauvaises nouvelles » compétence communicationnelle des étudiantes en pratique sage-femme

par Kathi Wilson, s.-f. aut., BA, MHSC(c)

RÉSUMÉ

L'annonce de mauvaises nouvelles aux patientes est une tâche communicationnelle qui est souvent difficile à accomplir pour les fournisseurs de soins de santé. Malgré cet état de fait, la littérature de l'éducation en sciences de la santé ne compte qu'un nombre relativement faible de recherches vouées à l'évaluation de cette compétence particulière. Tout comme dans le cas des autres fournisseurs de soins de santé, on s'attend à ce que les sages-femmes autorisées du Canada disposent des connaissances et des compétences requises dans ce domaine de la communication. Au sein du Programme de formation des sages-femmes de l'Ontario, on s'attend à ce que les étudiantes de dernière année deviennent compétentes en ce qui concerne la gestion des situations impliquant le décès / la fausse couche pendant la grossesse; toutefois, les précepteurs ne peuvent compter que sur peu d'encadrement à l'égard de l'évaluation de cette habileté. Le présent article passe en revue la littérature pertinente portant sur l'évaluation de « l'annonce de mauvaises nouvelles » et sur les outils d'évaluation en milieu de travail dans le domaine de la formation en santé, en plus de proposer l'utilisation d'une fiche de consultation clinique faisant appel à une version modifiée de l'outil Breaking Bad News Assessment Scale pour encadrer et orienter les précepteurs. La poursuite de l'exploration de la fiabilité, de la validité et de l'acceptabilité (aux yeux des précepteurs) de cet outil s'avère requise.

MOTS CLÉS

Annonce de mauvaises nouvelles, formation en pratique sage-femme, évaluation du rendement, évaluation en milieu de travail

Cet article a été soumis à l'examen collégial.

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INTRODUCTION

One of the most difficult tasks confronting health care providers is that of conveying information to patients and clients that is "sad, bad, or difficult."[1] In the health education literature, this task has become known as "breaking bad news" (BBN). Although much of the literature regarding BBN focuses especially on physicians and medical learners in oncology and trauma care,[1] it is increasingly acknowledged that a variety of health care professionals may be called upon to break bad news.[2,3] The overwhelming consensus in the literature is that BBN is distressing for providers, patients, and patients' families;[4] is often managed poorly;[5] and can lead to poor psychosocial outcomes for patients.[6] This has led to the conclusion that practitioners and learners require training and assessment in BBN, both as an independent clinical task[7] and as part of the larger domain of communication skills.[8]

In the Ontario Midwifery Education Program (OMEP), midwifery students in the third clinical placement (Maternal and Newborn Pathology) are expected to demonstrate competence in situations involving loss during childbearing.[9] This competence is a subdomain of education and counselling skills, part of the larger target domain of communication skills;[9] as well, it is a new skill to be mastered in this placement, which focuses on pathological conditions in pregnancy, childbirth, and the newborn (which would be expected to be sources of bad news). Although the manual provided to midwifery preceptors to assist them in teaching and assessment blueprints many of the competencies that students must acquire during their education and delineates detailed rubrics for these competencies, no rubrics are provided for this particular and important skill.[10] Yet, within their core competencies, entry-level midwives in Canada are expected to have what are described as "knowledge of issues related to grief and loss" and "the ability to counsel and support the woman and her family in responding to grief and loss during childbearing."[11] Therefore, it is important that midwifery education assesses skills that involve BBN adequately and reliably in order that graduates can perform them in a manner that most benefits their clients.

Because the scope of midwifery care is, as stated in the *Midwifery Act* of 1991, "the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries,"[12] it might be thought that midwives may break bad news less frequently than do physicians, making that skill more difficult to assess reliably during student clinical placements,

owing to lack of opportunity. However, the definition of bad news has been broadened in the medical literature to mean not just death or a potentially fatal diagnosis but to include, according to Ptacek and Eberhardt, "situations where there is either a feeling of no hope, a threat to a person's mental or physical well-being, a risk of upsetting an established lifestyle, or where a message is given which conveys to an individual fewer choices in his or her life."[13] In essence, "the determination that the event entails bad news lies, for the most part, in the mind of the receiver."[13] Thus, although midwives are involved in BBN about the less common events of intrauterine fetal demise and spontaneous abortion, many other clinical situations can be interpreted by clients as bad news. Positive genetic screen results; abnormal cervical screening results; fetal abnormalities detected antenatally; diagnoses of pregnancy-related conditions that can result in significant changes in plan and/or the client's concept of self; unexpected abnormalities in the newborn; and positive newborn screens for inborn errors of metabolism and other neonatal conditions can all be regarded as part of the domain of "bad news" that can evoke sensations of loss and grief for a woman and her family. Hence, many opportunities exist for the assessment of midwifery students in the clinical placement setting.

> The overwhelming consensus in the literature is that breaking bad news is distressing for providers, patients, and patients' families, is often managed poorly, and can lead to poor psychosocial outcomes for patients.

The literature on the assessment and teaching of BBN and other communication skills largely features the use of the Observed Structured Clinical Examination (OSCE) or simulated patients or both.[2,14–18] Although useful in teaching and in providing a formative assessment of communication competency,[7,19] simulation-based assessment of skills is believed, at best, to perform at the "shows how" level of Miller's pyramid (Figure 1).[20] As Rethans et al. suggest, the "shows how" performance is equivalent to a competency assessment, whereas "does" (what Miller delineates as the "action" tip of the pyramid[20]) encapsulates the assessment of performance—that is, what is done in actual practice.[21] Evidence has indicated that significant differences exist

art feature

Brescia Nember-Reid

about the artist

Brescia Nember Reid is a senior midwifery student at Ryerson University and multifaceted artist, working in paper cut outs, shadow projections, and song. Previous works include the shadow-puppet musical "The Day You Died And The Hour You Were Born" (Rhubarb Festival), as well as zines "Where Have All The Placentas Gone?" and "Stork Scissor Story". Brescia is a graduate of the Assaulted Women and Children's Counsellor/Advocate program of George Brown College, the Expressive Arts program at Haliburton School of Art, and founder of Drawing With Knives Shadow Puppetry co. Upcoming involvements include illustrations in the book "Natal Signs" edited by Nadya Burton, and shadow-puppetry in "The Spirit of Birth" documentary by Rebeka Tabobondung.

about the artwork

The medium - paper cut-out - is hand-drawn and hand-cut black paper, using xacto knives. This medium appeals to me as it offers continuity of the lines, as well as the depth of being multi-layered. It requires both fluidity and precision. I also chose this medium in part, because it embodies the diligence and skill of midwifery work. In projecting light through the paper cut-outs as shadow puppets, new versatile images can be created.

The imagery combines elements of textbook-inspired anatomy-physiology, botany/plant knowledge, with creative interpretations of pregnancy, birth, and midwifery. In addition, inspiration is drawn from considering the cycles of life, honouring mortality, and respecting the mystery in all things.

The illustration "Fetal Circulation" was a poster submission at the 2014 Association of Ontario Midwives conference, marking 20 years of regulated midwifery in Ontario, and celebrating midwifery's various longstanding histories.

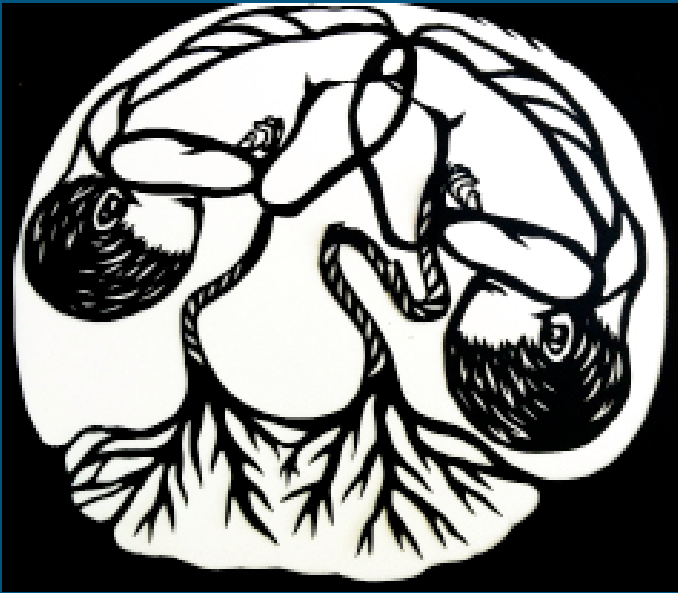*Trans Parent*, paper cut-out

art feature

Womb, paper cut-out

Pregnant in Window, paper cut-out *Fetal Circulation,* paper cut-out ▶

Twin Babies, paper cut-out

Crone and Moon, paper cut-out, shadow projection

Pregnant, with hair, mixed media

Three Babies, paper cut-out

art feature

featuring Sandra Cisneros

about the poet

by Chris Sternberg

Sandra Cisneros writes her stories and poetry in both Spanish and English, often combining the two languages. Her work reflects her Mexican-American heritage, and she is considered a leading Latina feminist writer, best known perhaps for her autobiographical novel, "The House on Mango Street". She was born in Chicago in 1954 and now lives in San Antonio, Texas. Her many awards for her work include a MacArthur Foundation grant, and she is credited with creating the "MacArturos", an informal group of the Latino award winners of the grant who work to inspire the young people of their community.

Her book of poetry, "Loose Woman" (1994), which includes this poem to her godchild Arturo Javier Cisneros Zamora, challenges traditional views of love, sexuality and female relationships. "Arturito the Amazing Baby Olmec" stands in contrast to many in this collection as a poem celebrating birth and the newborn's connection to his family and to Mexican culture.

Immediately within the title of the poem, the baby is linked to the culture of his parents through his identity as "Baby Olmec". The Olmec civilization, acknowledged to be the oldest in Mexico, is thought by some to be the "mother culture" of Mesoamerica. Familial and religious ties to the narrator are "by way of water", through baptism, when traditionally in Catholicism the godparents are chosen for a newborn, thus providing for the moral upbringing of the baby as well as strengthening family and community ties. So, even before the poem begins, a connection to culture and family is well established.

Throughout the poem, this theme is re-emphasized. As is often seen in Cisneros' writing, she uses a mixture of her two native languages, choosing the word or phrase which best expresses the intentions/feelings of the narrator. She acknowledges this in the line contrasting "Oh" and "Ay" as expressions of surprise and delight at the moment of first encounter with the newborn. Her references to Mexican culture continue throughout the poem: The declaration that the baby arrives on

"Mexican time" could re-enforce a stereotype, but also potentially emphasizes the fluidity of the perception of time in comparison to Anglo culture. Further on in the poem, the baby is sheltered by corn, an indigenous food which in Mexico symbolizes both spiritual and cultural sustenance and survival.

The poem then moves to the relationship between the baby and his godmother, the narrator. Cisneros humorously questions her suitability as a godmother. Arturito ends up with the "the aunt who dislikes kids and Catholics". In Latino society, godparents take on the responsibility for moral guidance in the child's upbringing. The godmother in this case provides the baby with three wishes which are to define the baby's character. (One is reminded of the three wishes from fairy tales). The guidance which the godmother provides is within a framework of social responsibility: The baby is given the example of historical persons who exemplify certain virtues. The godmother wishes the baby to become, like these role models, a noble, wise and generous person, especially in respect to those needing support and advocacy. The baby will ultimately be seen as having a responsibility to community, to work to right the world which is "a mess". Thus, Cisneros reveals her own dedication as activist within her vocation as writer. Within this poem we also recognize what it has in common with other poems celebrating a birth. Here, as elsewhere, the child itself is referred to in superlatives, in this case, "amazing", "a wonder" and is compared to "an ancient god". The joy and awe in this poem, as in others, reflect what we continue to call the "miracle" that birth remains for all of us.

The poem ***Arturito the Amazing Baby Olmec Who is Mine by Way of Water*** is from the book "Loose Woman" (1994), pp 98-99, Alfred A. Knopf Inc. (New York).

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Arturito the Amazing Baby Olmec
Who is Mine by Way of Water

By Sandra Cisneros

Arturito, when you were born
the hospital gasped when
they fished you from your fist of sleep,
a rude welcome you didn't like a bit,
and I don't blame you. The world's a mess.

You inherited the family sleepiness and overslept.
And in that sea the days were nacre.
When you arrived on Mexican time,
you were a wonder, a splendor, a plunder,
more royal than any Olmec
and as mysterious and grand.
And everyone said "¡Ay!"
Or "Oh!" depending on their native tongue.
So, here you are, godchild,
a marvel that could compete with any ancient god
asleep beneath the Campeche corn. A ti te tocó
the aunt who dislikes kids and Catholics,
your godmother.   Don't cry!
What do amazing godmothers do?
They give amazing gifts. Mine to you –
three wishes.

First, I wish you noble like Zapata,
because a man is one who guards
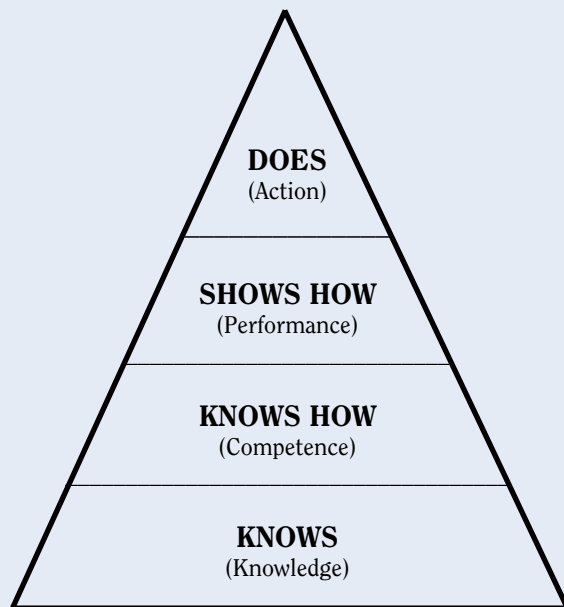those weaker than himself.
Second, I wish you a Gandhi wisdom,
he knew power is not the fist,
he knew the power of the powerless.
Third, I wish you Mother Teresa generous.
Because the way of wealth is giving
yourself away to others.

Zapata, Gandhi, Mother Teresa.
Great plans! Grand joy! Amazingness!
For you, my godchild, nothing less.
These are my wishes, Arturo Olmec,
Arturito amazing boy.

Escribi este poema para mi ahijado, Arturo Javier Cisneros Zamora,
el 8 de febrero, 1993, en San Antonio de Béxar, Tejas.

Figure 1. *Framework for clinical assessment (Miller's pyramid).*

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                    /\
                   /  \
                  /    \
                 / DOES \
                /(Action)\
               /----------\
              / SHOWS HOW  \
             /(Performance) \
            /----------------\
           /   KNOWS HOW      \
          /   (Competence)     \
         /----------------------\
        /        KNOWS           \
       /      (Knowledge)         \
      /----------------------------\
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between examinees' performances in controlled simulations and their behaviour in the clinical practice setting.[21]

Specifically with respect to communication skills, Henry et al. state that simulation is ultimately an incomplete assessment tool:

> *Assessing residents' communication skills using standardized patients is analogous to predicting baseball teams' performance by watching exhibition games. You can get some information about teams' relative abilities, but the only information that counts is how the teams perform during the regular season.[22]*

Apart from the potential problems of the reliability and validity of using simulation as the sole means of assessing communication competency,[23] there are insurmountable issues with respect to the feasibility of using either OSCE or simulated patients for assessing communication in midwifery clinical placements. Unlike medical students or residents, midwifery students are given clinical placements in one of the 104 midwifery practices across the province; generally there are three or four students within a practice. Their final year of clinical placement may situate them at a great distance from their home institutions, and they do

not return for tutorials (online) or examinations (at the closest educational institution). Communication skills in conducting health histories, providing informed choice, and counselling and education are taught in the introductory courses before clinical placement.[24] Subsequent teaching for the advancing and mastering of the student's skills, along with the assessment of competencies, is done by preceptors within the midwifery practice where the student is placed.

By default then, skills must be assessed through observation. However, as students progress through their clinical placements, it is expected that less scaffolding and direct supervision by the preceptor will be required. Regardless, preceptors will supervise the performance of skills that may be less commonly performed by senior students; similarly, students can request supervision if they feel uncertain about performing a skill. Although a full discussion of mentorship and assessment issues is beyond the scope of this article, it is important to note that the preceptor as both teacher and assessor can present a role conflict that can create bias, thereby threatening both the reliability and validity of the assessments.[25,26] This must be taken into account when developing and implementing an observational assessment tool for BBN.

In the past, the use of observation-based assessment in medical education was challenged and characterized as unreliable (and therefore lacking validity) owing to subjectivity, lack of standardization, and sampling limitations that prevented the "systematic accumulation of reliable information."[20] More recently, however, observational "workplace-based assessment" has been promoted as a powerful tool for formative assessments that change learners' behaviour,[27] and tools such as the Mini-Clinical Evaluation Exercise (mini-CEX), clinical encounter cards, Clinical Work Sampling, and Direct Observation of Procedural Skills have been proposed.[27] Although the proviso that validity and reliability are questionable when the observed assessment is unstructured and unstandardized still stands,[28] the following is currently acknowledged:

> *Assessment development seems to have come full circle from patient-based examinations via structured simulations back to observations in real practice. The difference is that now observations in real practice are better structured and more attention is paid to adequate sampling.[23]*

Further, some have suggested that direct observation

provides a valuable template for formative feedback that reinforces clinical skills and remediates deficiencies[29] and is indispensable for teaching and evaluating real-world communication skills.[22]

The tool used for assessing midwifery students' skill in BBN must be one that easily provides a largely formative assessment of their competence in this area (although ultimately the pooled assessments at the end of placement would contribute to the summative assessment of communication). The workplace-based tool that is most readily adapted to this assessment consists of clinical encounter cards.

It is paramount that there is a set of criteria upon which to base the rating—not only to provide reliability, but also to act as a basis for meaningful and constructive feedback to students.

Clinical encounter cards (CECs) were developed at McMaster University as an alternative or supplement to the in-training evaluation reports that are used as a form of midterm and final evaluation of medical students during clinical rotations.[30] As originally conceived, CECs were index-sized cards carried by medical students; the cards were to be given to and completed by residents or faculty after a clinical encounter. The cards contained two elements: (1) a rating of clinical competence on a five-point Likert scale and (2) specific comments on the student's performance, to be shared with the student both verbally and in written form.[30] Students were free to choose their assessors during the rotation and submitted the cards before the end of the rotation so that the data could be pooled for summative evaluation.[30] Although the CEC system has not as yet been extensively studied, the studies that have been done have found it to be feasible and to have an acceptable level of reliability and validity, provided that data on a sufficient number of encounters are collected.[27,31] Hatala and Norman calculated that approximately eight encounters were required for a reliability coefficient of 0.8 or more.[30] From the perspective of students, the CEC system improved satisfaction with the feedback process,[31–33] and some educators suggest that CECs be used primarily for formative purposes and not as a high-stakes summative

tool.[34]

This system could easily be adapted to help provide midwifery students in clinical placement with formative assessments on BBN. Because the midwifery student (being located in one midwifery clinic with a small number of preceptors) is significantly less itinerant than a medical trainee, there would be less need for the student to carry encounter cards for BBN or present them to preceptors prior to assessment. In fact, BBN situations cannot always be anticipated, so it would be most important that the encounter cards be readily accessible to the student and preceptor (for example, by being available in the clinic setting). One significant difference between the CECs proposed for this purpose and those intended for use by medical students is that the BBN-specific CECs would assess only this subdomain, while CECs in general have been used for the assessment of several domains within a clinical placement (for example, history taking, physical examination, professional behaviour, technical skill, case presentation, diagnosis, and therapy).[30]

In order for observed assessments to be reliable and valid, they must be grounded in a rubric that provides structure and standardization.[28] The need for a rubric does not imply the need for an assessment checklist; in fact, it has been suggested that the atomization created by checklists can lead to trivialization and thereby threaten validity.[35] Further, the use of global rating scales or judgments does not cause a significant decrease in reliability, as long as sampling is adequate;[23] global, more subjective ratings can permit the inclusion of more qualitative aspects of the assessed person's actions.[23,35] This is particularly germane to assessments of more complex competencies, such as communication (in particular, difficult communication tasks).[35] However, it is still paramount that there is a set of criteria upon which to base the rating—not only to provide reliability, but also to act as a basis for meaningful and constructive feedback to students. This may be of particular importance in the OMEP, many students of which have reported a lack of fair evaluation, a perception of preceptors as having difficulty in providing positive and constructive feedback, and a sense of a power imbalance created by the dual "preceptor/assessor" role.[36]

Despite the large amount of published literature on BBN, remarkably little of that literature is devoted to specific assessment rubrics for this communication task; this could in part be due to the lack of protocols for BBN that are based on empiric evidence.[6] Although several studies examining the assessment of BBN used more-generic communication

assessment tools, a structured rating tool called the Breaking Bad News Assessment Scale (BAS) was developed in 1990 and tested in videotaped scenarios using simulated physicians (simulated by a range of health professionals, from a nurse and a medical statistician to medical students, residents, generalists, and consultants) and simulated patients.[37] The content of the tool was determined through a literature search to identify the key behaviours of clinicians in BBN. These were distilled into a group of five sections that the authors proposed would chronologically occur in a clinical interaction involving the breaking of bad news: (1) setting the scene, (2) breaking the news, (3) eliciting concerns, (4) giving information, and (5) addressing general considerations.[37] Each section listed behaviours that were associated with good BBN skills, and the rater ranked the performance of the key behaviour on a five-point Likert scale in order to avoid "false dichotomization" in the assessment.[37]

The internal consistency among the five components of the scale was high, with a Cronbach's alpha of 0.93, while inter-rater variability was moderate to good. The authors felt that the value of the BAS would be in "identifying the specific strengths and weaknesses of the health professional or student to focus effective teaching"[37] but that the BAS could also be utilized for summative evaluation. However, despite the authors' distillation of content in developing it, the tool is lengthy, each section having four to five questions. Each of the questions has five bulleted "sub-questions" guiding assessments for that question and there are a total of 23 questions in the tool (equivalent to what the authors regarded as the 23 "key behaviours" in BBN). Each of the 23 questions is separately rated with the Likert scale. Certainly the level of detail might be a significant deterrent to acceptability by raters in an educational setting, especially if the intent is for use as a formative assessment. It would also be difficult to use such a detailed tool to assess a clinical observation that was not recorded in some fashion, as assessors could potentially struggle to recall, for example, whether the doctor unplugged the telephone, showed the patient where to sit, or asked some of the specific questions suggested in the tool.[37]

For this reason, Schildmann et al., in a study evaluating the effectiveness of a teaching module in BBN for medical students, modified the BAS so as to make it easier to utilize for assessment. While maintaining the five sections of the original BAS, the modified BAS (mBAS) contains a Likert scale from 1 to 5 only for each section, along with a specific guide to rating the section on the basis of the presence or absence of three to four clearly delineated behaviours.[18] At the same time, the authors developed a global BAS (glBAS) that reflected the five sections of the mBAS and used a Likert scale but used one exemplary question to guide the assessment. Although the purpose of the study was to assess the effectiveness of the teaching session rather than the reliability of the measurement instruments, comparisons that are useful for consideration were drawn between the mBAS and the glBAS. Although there was good correlation of scores between the mBAS and glBAS when each was used by the independent raters in the study, there was low correlation in the glBAS scores assigned by the independent raters and the simulated patients. The authors postulated that a reason for the second finding was inadequate training of the simulated patients in the use of the less structured glBAS; this suggests that without an understanding of the underlying structures and concepts of the assessment on the part of the assessor, global ratings of BBN may become less reliable.

In order to adapt the mBAS to a CEC system for midwifery students, some alterations are required. First among these is the elimination of the "setting the scene" section. This segment of the tool assumes that the physician who is breaking the bad news is unknown to the patient and that BBN is an event that can be planned or predicted in advance. In the context of midwifery practice and under the standard of continuity of care,[11] the client is already known by a small group of midwives. Eggly et al. suggest that since what constitutes bad news is determined subjectively by the person who receives it, it is not always possible or even desirable to "set the scene." They further suggest that health care providers "prepare for all interactions in which they will disclose any information, from the most momentous to the most trivial, by engaging in communication behaviours appropriate for delivering potentially stressful information."[4]

"Setting the scene" also presumes that the BBN interaction is always a face-to-face event. But although an in-person interaction is deemed to be preferable, it is not always possible, especially if time constraints require immediate notification and follow-up (as with genetic screening results). Eliminating this element of the assessment permits the assessment tool to be used for observing a BBN interaction that occurs on the telephone, a sometimes unavoidable event.[38]

Eggly et al. also challenged the concept (contained in

many BBN guidelines and reflected in the BAS and mBAS) that a BBN interaction "is limited to the physician-patient dyad."[4] Their observational data indicate that when patients are accompanied by companions or significant others, "these companions participate actively in the interactions."[4] Although BBN guidelines were developed partly to reflect a more patient-centred approach,[39] more-contemporary conceptions of such an approach propose that "the patient should be the judge of patient-centred care"[40] and that the patient-centred approach "seeks an integrated understanding of the patients' world."[40] Therefore, an important part of assessing BBN interaction includes communication with the chosen companions of the patient; this is particularly important in childbirth care, when there are usually two parents who can be affected by bad news concerning a fetus or baby. The language in the mBAS for midwifery should be altered to reflect this dimension (Appendix 1). Given that the internal consistency of the

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A good performance in one area of difficult or sensitive communication would be expected to be concurrent with performance in a similar communication task.

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original BAS tool was high, eliminating the "setting the stage" element should not alter the reliability substantially. However, it should be noted that both the BAS and mBAS were intended for single administration[18,37] and that the proposed use of the midwifery mBAS is as a rubric for the assessment of a series of observed clinical encounters in BBN. As previously mentioned, Hatala and Norman estimated that approximately eight encounters were required to ensure the reliability of CECs.[30] Although those authors did not specify the number of raters required, one could assume that there would be more than one rater in the medical clerkship rotation. Although the number of raters within a midwifery practice would be limited, those raters would be experienced preceptors, thereby increasing reliability. (As Hatala and Norman noted, inter-encounter reliability was higher when attending physicians, rather than resident, were CEC evaluators).[30] As Richards et al. suggested, reliability in the CEC system is compromised by a high number of raters, so the use of fewer, trained

observers is more desirable.[34] Although a reliability study of this modified assessment tool would of necessity need to be done at a program level (given the small number of students in each placement), there is already evidence of reliability in each of the tools being utilized in this setting.

Of course, the validity of the interpretations made from the assessments should also be considered. Referencing Kane's perspective on validity in performance assessments,[41] the first inference would be from the multiple observations of BBN assessed by precepting midwives to an observed score, a global rating determined by use of the rubric in the midwifery mBAS. Although changes in scores might be anticipated as formative feedback is provided throughout the placement, an overall score could be determined at the end of the 13 weeks of placement. Moving from the observed score to the universe of generalization (the "universe score"[41]) would involve comparing the outcome of the assessment of this particular task to outcomes for similar tasks; within the "education and counselling" subdomain of midwifery communication skills, one might expect concurrent validity with assessment outcomes in situations involving sexuality issues or concerns.[9] A good performance in one area of difficult or sensitive communication would be expected to be concurrent with performance in a similar communication task. In the inference from universe score to scores in the target domain of communication skills, the validity argument would propose that good performance in BBN would predict good performance in the variety of communication task skills under consideration (which would be assessed with a variety of tools). If this is not the case, then the reliability of the midwifery mBAS needs to be re-examined.

Any assessment tool must be both feasible and acceptable, and a primary prerequisite for implementing the midwifery mBAS is the adequate education of the preceptors who will be using it. This education can be accomplished both through written communications and through teleconferences. All preceptors are contacted personally through e-mail or regular mail at the beginning of each clinical placement; the introduction of this tool in the Maternal and Newborn Pathology placement, along with an explanation of its components and use, could be part of that communication. Faculty teleconferences held at the beginning of and during placement in order to address preceptors' questions and concerns would also be ideal forums for the discussion of this tool. Key elements of preceptor education would include the use of the CEC for written assessment and feedback and the use of the

rubric provided to guide the scoring of the encounter. Uptake of the tool could be promoted by emphasizing the usefulness of the rubric in providing constructive feedback to the student on a task expected to be stressful for both student and preceptor. As van der Vleuten et al. state, "it is imperative that [assessment] should produce meaningful information to the learner."[42]

The success of this assessment tool in terms of acceptability and feasibility would need to be assessed at the program level. However, a tool that generates several formative assessment "data points"[42] through structured observation has the potential to diffuse the perceived imbalance between preceptor and student and student perceptions of purely subjective bias in assessment.[36] It is certainly plausible that the use of CECs for a variety of assessments in clinical placements in the OMEP could through the aggregation of multiple observational samples contribute to an improved summative evaluation of midwifery student performance that benefits both the student (through improved feedback) and the program (through the reliable and valid assessment of students' skills.

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Appendix 1: *Midwifery modified Breaking Bad News Assessment Scale clinical encounter card*

<table>
<tr><td colspan="2" align="center">Assessment Rubric</td></tr>
<tr>
<td>

Breaking the News:

Did the midwife let the woman and her family set the pace for the delivery of the bad news?
1. = The midwife
   a. Delivered information at an appropriate rate and
   b. Paused repeatedly and
   c. Checked that the woman and her family understood and assimilated what had been said before giving more information and
   d. Asked the woman/family how much information they wanted
2. = three of behaviour patterns a – d
3. = two of behaviour patterns a – d
4. = one of behaviour patterns a – d
5. = none of the behaviour patterns a – d

</td>
<td>

Information Giving:

Did the midwife explain any information given so that the woman/family understood?
1. = The midwife has:
   a. Given information in an ordered and logical manner and
   b. Checked whether the woman/family understood the information and
   c. Summarized the information in a structured manner
2. = two of the behaviour patterns a – c
3. = one of the behaviour patterns a – c
4. = approaches to a or b or c are observable
5. = no approaches to a or b or c are observable

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<tr>
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Eliciting Concerns:

Did the midwife specifically invite questions?
1. = The midwife invited questions repeatedly verbally and non-verbally (e.g., by pausing, gesture).
2. = The midwife invited questions verbally only at the end of the discussion.
3. = The midwife allowed questions only by using an appropriate rate of information giving only.
4. = The midwife did not allow for any questions.
5. = The midwife ignored the woman/family's questions.

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<td>

General Considerations:

How many of the key areas of the woman/family's concerns were *touched* upon?
Key areas: treatment; prognosis; feelings and emotions; family and relationship issues; effect on social circumstances
1. = all 5 key areas were touched upon
2. = 3 – 4 key areas were touched upon
3. = 2 of the key areas were touched upon
4. = 1 of the key areas was touched upon
5. = none of the key areas was touched upon

</td>
</tr>
</table>

<table>
<tr><td colspan="2" align="center">Global Rating</td></tr>
<tr>
<td>

Breaking the News:

Altogether, how well did the midwife manage breaking the news?

Very good	Good	Medium	Poor	Very poor
1	2	3	4	5

</td>
<td>

Information Giving:

Altogether, how well did the midwife manage information giving?

Very good	Good	Medium	Poor	Very poor
1	2	3	4	5

</td>
</tr>
<tr>
<td>

Eliciting Concerns:

Altogether, how well did the midwife manage eliciting the woman and her family's concerns?

Very good	Good	Medium	Poor	Very poor
1	2	3	4	5

</td>
<td>

General Considerations:

Altogether, how good was the midwife's communication behaviour in this interview?

Very good	Good	Medium	Poor	Very poor
1	2	3	4	5

</td>
</tr>
</table>