

SHORT COMMUNICATION

Evaluation of Knowledge of Breaking Bad News among Doctors and Nurses in Tertiary Care Hospitals Across PakistanSanum Kashif^{1*}, Khalid Mehmood²**ABSTRACT**

Objective: To establish the knowledge and skill of breaking bad news (BBN) among doctors and nurses in tertiary care hospitals of Pakistan.

Study Design: Cross-sectional descriptive study.

Place and Duration of Study: The study was carried out on doctors and nurses in tertiary care hospitals across Pakistan from 20th March 2021 to 21st May 2021.

Materials and Methods: A total of 60 responders from different tertiary care hospitals completed a questionnaire-based survey on the knowledge and skill of breaking bad news. The questionnaire was designed with the help of the guidance of experts of the Shaheen palliative care project, and its reliability and validity were checked by SPSS.

For data collection, convenience sampling was used and to present the distribution of responses, frequencies and percentages were used. The sample size was calculated from the previous study using the WHO sample size calculator (2.2a for population proportions). Data was entered in Excel and analyzed using SPSS version 16.

Results: Of the total participants, almost all 59 (98.3%) had the experience of breaking bad news to patients, 32 (53.3%) knew SPIKES protocol, whereas only 10 (18.2%) followed SPIKES model in delivering bad news.

Conclusion: Among Pakistani doctors and nurses, the knowledge and skill of delivering breaking bad news is not satisfactory. Although breaking bad news is a part of training at different levels, it should be a part of the curriculum at all doctors and nurses to improve their communication skills, especially in terminal care.

Key words: Evaluation, Knowledge, Tertiary Care Hospital.

How to cite this: Kashif S, Mehmood K. Evaluation of knowledge of Breaking Bad News (BBN) among doctors and nurses in tertiary care hospitals across Pakistan. 2023; 4(3): 347-351. doi: <http://doi.org/10.37185/LnS.1.1.257>

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Introduction

Good communication skills are a vital part of clinical competency. Breaking bad news is an essential clinical tool that is commonly used in the setting of routine practice by following an established SPIKES protocol; communicating empathetically makes the

difficult task of delivering bad news easier for the health care provider, and it assists in enhancing the communication between patient and the family.^{1,2} The SPIKES protocol was first described by American experts as giving bad news to patients and their families Baile et al. 2000; Kaplan 2010, but the patient's ethnicity, cultural values, and hospital organization, must be considered.² This Six-Step Protocol for Delivering Bad News is SPIKES: S for setting up the meeting, P is assessing the patient's perception, I for achieving the patient's invitation, K is providing knowledge and information to the patient, E is addressing the patient's emotions with empathic responses and S for strategy and summary.³

According to a survey result by Bousquet et al., about 60 % of oncologists break the bad news to patients

¹Department of Anesthesia
Combined Military Hospital (CMH), D.I Khan, Pakistan

²Department of Anesthesia
Combined Military Hospital (CMH), Sialkot, Pakistan

Correspondence:

Dr. Sanum Kashif

Associate Professor, Anesthesia
Combined Military Hospital (CMH)
D.I Khan, Pakistan

E-mail: sanumdr@gmail.com

Funding Source: NIL; Conflict of Interest: NIL

Received: May 05, 2022; Revised: Jan 30, 2023

Accepted: Mar 13, 2023

about 5–20 times in a month, among which 14 % have to deliver bad news more than 20 times in a month.⁴ A study conducted among doctors from various parts of Pakistan involved in palliative care also reported that 40% of the doctors could not break bad news properly and were willing to have formal training in breaking bad news (BBN).

There is ample evidence that patients cope better with serious illnesses if they are informed. In Saudi Arabia, a large population of oncology patients remain uninformed about the prognosis and level of their disease. According to a survey among incurable cancer patients in Saudi Arabia, 67% of doctors showed that they would inform diagnosis to the patient rather than the attendants. Moreover, 99% of patients preferred knowing all about their disease, and 100% rejected withholding information.⁵

Initially, the SPIKES protocol was made for oncology patients, specifically when the end-of-life care or palliative care is indicated. Unlike protocols for the management of medical illnesses such as diabetes or hypertension, practice guidelines for nurses to deliver bad news and provide support to their patients and families are quite limited.⁶

The literature showed that most complaints about doctors are concerned with communicational issues rather than competency. Patients would like doctors who can diagnose and treat their illnesses and communicate with them effectively.^{7,8} In a study conducted, among doctors in Pakistan regarding knowledge and skill of BBN, of the total, 41 (42%) said that would disclose the diagnosis and all the information to the patient; 38 (39%) said they would talk to the patient first regarding how much information he or she wants and then disclose.⁹

In a research regarding patients' views and beliefs about breaking bad news, about 40% of patients believed that full disclosure was their fundamental right. Even children who were given relevant information about their diagnosis and treatment plan at the start of the treatment showed a lesser amount of anxiety and depression. Therefore, all doctors need to be prepared to break the bad news to those patients who wish to have all the information.¹⁰

The aim of this study, therefore, is to assess the knowledge and skill of doctors and nurses, especially

in relation to the SPIKES model of breaking bad news to patients.

Materials and Methods

This questionnaire based cross-sectional study, conducted across tertiary care hospitals of Pakistan, from 20th March 2021 to 21st May 2021. The questionnaire consisted of two sections. The first section included information regarding age, gender, level of health care provider (doctors/nurses), any experience of breaking bad news, and knowledge regarding SPIKES protocol. The second section was related to the SPIKES protocol, which consisted of 5 items. The items were based on the main steps of breaking bad news of the SPIKES model. Data analysis was carried out using SPSS version 16. Frequency and percentages of all variables were recorded.

Results

Of the total 60 participants, 35 (58.3%) were male, and 25 (41.7%) were female, with age group between 18–45 years, mainly specialists 24 (40%), medical officers 16 (26.7%), nurses 9 (15%) followed by residents 7 (11.7%) and house officers 4 (6.7%). Almost all 59 (98.3%) had the experience of breaking bad news to patients, but 32 (53.3%) had the knowledge of SPIKES protocol, and only 10 (18.2%) followed SPIKES protocol in breaking bad news (Table 1).

Regarding questions proposed through the SPIKES protocol, 40 (80%) had given correct responses regarding setting, and 44 (73.3%) had the idea of when to deliver bad news. All responders, i.e. 100% knew that bad news ideally shouldn't be given on the phone. The assessment of patients' knowledge about their health condition, before giving bad news, was correctly identified by the majority, 56 (96.6%). Only 38 (65.5%) had the idea of how much information should be provided at one time, and mostly 58 (88.1%) had given the correct response about what should be the doctor's response after delivering bad news to a patient (Table 2).

Discussion

Specific components of the protocol were evaluated in different previous studies. Eighty-two percent of the physicians were unaware of the protocol, and 83.8% had no training. In contrast, in our study, 53.3% had knowledge regarding SPIKES protocol,

Table 1: Descriptive statistics of participants who filled out the questionnaire n (%)

Participants	n (%)
Sex	
Male	35(58.3%)
Female	25(41.7%)
Age in years	
18-24	13(21.6%)
25-34	25(41.6%)
35-45	22(36.6%)
Level of healthcare provider	
Nurses	9(15%)
House officer	4(6.7%)
Medical officer	16(26.7%)
resident	7(11.7%)
specialist	24(40%)
Experience of BBN with patient	
Yes	59% (98.3%)
No	1% (1.7%)
Knowledge of SPIKES protocol	
Yes	32(53.3%)
No	28(46.7%)
Follow SPIKES protocol	
Yes	10(18.2%)
no	50(81.8%)

Table 2: Response of participants, Question numbers, and frequencies of correct responses n (%)

Q.no	Questions	Correct Response	n (%)
1	Bad news should be given (where)	In a comfortable room	48(80%)
2	Bad news should be given (when)	At specified time	44(73.3%)
3	Bad news ideally be given on the phone	No	100%
4	Before giving bad news, should the knowledge of the person be assessed	Yes	56(96.6%)
5	It is essential to give all information at once	No	38(65.5%)
6	After saying unpleasant news, should the doctor leave the room	No	52(88.1%)

and 46.6% had no knowledge regarding SPIKES protocol for BBN.¹¹ In the current study, among the items in the questionnaire, the most dominant one was not giving bad news by phone (100%) (Table 2), which is the same as a study by Mostafavian Z et al. in Journal of family medicine and primary care and the least prevalent question was placing hand on the shoulder (24.3%). This study showed that 81.4% of doctors agreed on giving the bad news in private, 72.9% agreed on giving relative hope to patients, and 67.1% agreed on evaluating patients' knowledge of his/her disease when giving bad news.¹² The aim of this study was to investigate the knowledge and skill

of doctors and nurses to give bad news to patients and attendants. Breaking bad news to oncology patients is one of the most difficult duties of doctors and in medical education.

In Farber et al. study, 63% of physicians had experienced a dangerous disease in their relatives and 17% had a personal experience of a serious disease. The results of this study showed that the personal experience of a life-threatening illness had a significant relationship with increased emotional support.¹³

Likewise, in our study and Farber et al. and Ghaffar inejad et al. there was no significant statistical

relationship between variables and giving bad news by telephone. In this study, none of the doctors told the patient bad news on the phone. In one study, 92% of doctors did not tell the bad news to the patient on the phone, and there was no significant relationship with other variables.¹⁴

In the Larizade MH et al. study, data analysis revealed that most nurses had good knowledge, but only 7.3% of cancer patients were aware of the prognosis and duration of their survival. On the other hand, a significant difference was seen between the gender groups ($p=0.004$), the groups of job experience ($p=0.041$) and the workplace ($p=0.031$) in knowledge level.¹⁵ In our study, 9(15%) responders were from the nursing side and but knowledge of the SPIKES protocol was only 53.3%, and only 18.2% followed SPIKES protocol.

These skills can be learned in continuing education programs or easily integrated into curriculum. In many Asian cultures, it is considered unnecessarily cruel to directly inform a patient of a cancer diagnosis. Consequently, this approach of preventing harm by keeping patients ignorant of their condition became a common practice worldwide. However, the notion that receiving such unfavorable information will invariably be psychologically detrimental has never been substantiated.¹⁶ Disclosing all the information in one visit may be too much information to comprehend for a majority of patients. Giving partial information remains the best strategy, since it has been observed that patients retain less than a quarter of the information imparted to them in one session. It is a common concept in India that patients do not want to know about their disease. The fact that 33/35 respondents felt that Indian patients would like to know about their disease reflects the change in Indian society; that in the past times, the doctors were supposed to decide the fate of the patients, but now the patient wants to know their disease, and take an active part in decision making.¹⁷

Studies conducted in India also showed that over 50% of oncologists did not have any training in BBN, and most of these oncologists requested formal training. Only 5/97 (5.15%) residents reported having received formal training in communication skills as undergraduate medical students, while 64 (66%) had witnessed bad news being broken by a

senior consultant.¹⁸

This study highlights the limitations of our current medical curriculum in helping medical professionals develop competence in communicating bad news. The study confirmed deficiencies in the curriculum, which may not be different from that of other medical universities in Pakistan, resulting in doctors being uncomfortable communicating bad news.

Limitations

The professionals' experiences may be institution-specific, and the subset of doctors surveyed in this study may not be representative of all doctors at this institution. However, due to the diverse nature of the surveyed professionals, we believe that the study does provide insights that can be used broadly to improve the undergraduate curricula as well as continuous training of doctors to improve their communication skills as per modern criteria and to address needs and goals for communicating bad news to patients and families.

REFERENCES

1. Al-Wahaibi A, Almahrezi A. An application of educational theories and principles of teaching and learning communication skills for general practitioners in oman. *Oman Medical Journal*. 2009; 24: 119-27 doi: 10.5001/omj.2009.26
2. Rosenzweig MQ. Breaking bad news: a guide for effective and empathetic communication. *The Nurse Practitioner*. 2012; 37: 1-4. doi: 10.1097/01.NPR.0000408626.24599.9e
3. Bumb M, Keefe J, Miller L, Overcash J. Breaking bad news: An evidence-based review of communication models for oncology nurses. *Clinical journal of oncology nursing*. 2017; 21: 573-80. doi: 10.1188/17.CJON.573-580
4. Bousquet G, Orri M, Winterman S, Brugière C, Verneuil L, Revah-Levy A. Breaking bad news in oncology: a metasynthesis. *Journal of Clinical Oncology*. 2015; 33: 2437-43. doi: 10.1200/JCO.2014.59.6759.
5. Karim SM, Zekri JM, Bassi S, Sadiq B, Abdelghany EM. Breaking bad news: Preferences of cancer patients in Saudi Arabia. *Journal of Palliative Care & Medicine Open Access*. 2015; 5: 207. doi: 10.4172/2165-7386.1000207
6. Adams AM, Mannix T, Harrington A. Nurses' communication with families in the intensive care unit—a literature review. *Nursing in critical care*. 2017; 22: 70-80. doi: 10.1111/nicc.12141
7. Merckaert I, Liénard A, Libert Y, Bragard I, Delvaux N, Etienne AM, et al. Is it possible to improve the breaking bad news skills of residents when a relative is present? A randomised study. *British journal of cancer*. 2013; 109: 2507-14. doi: 10.1038/bjc.2013.615
8. Buckman R. 2. Why Breaking Bad News Is Difficult. In *How to Break Bad News 2017* May 22 (pp. 15-39). University of Toronto Press.

9. Jameel A, Noor SM, Ayub S. Survey on perceptions and skills amongst postgraduate residents regarding breaking bad news at teaching hospitals in Peshawar, Pakistan. *JPMA-Journal of the Pakistan Medical Association*. 2012; 62: 585-9.
 10. Ishaque S, Saleem T, Khawaja FB, Qidwai W. Breaking bad news: exploring patient's perspective and expectations. *Journal of the Pakistan Medical Association*. 2010; 60: 407-11.
 11. Fisseha H, Mulugeta W, Kassu RA, Geleta T, Desalegn H. Perspectives of Protocol Based Breaking Bad News among Medical Patients and Physicians in a Teaching Hospital, Ethiopia. *Ethiopian Journal of Health Sciences*. 2020; 30: 1017-26. doi: 10.4314/ejhs.v30i6.21.
 12. Mostafavian Z, Shaye ZA. Evaluation of physicians' skills in breaking bad news to cancer patients. *Journal of family medicine and primary care*. 2018; 7: 601-5. doi: 10.4103/jfmpc.jfmpc_25_18
 13. Acebedo-Urdiales MS, Jiménez-Herrera M, Ferre-Grau C, Font-Jimenez I, Roca-Biosca A, Bazo-Hernández L, et al. The emotion: A crucial component in the care of critically ill patients. *Nursing ethics*. 2018; 25: 346-58. doi: 10.1177/0969733016643863
 14. Imanipour M, Karim Z, Bahrani N. Role, perspective and knowledge of Iranian critical care nurses about breaking bad news. *Australian Critical Care*. 2016; 29: 77-82. doi: 10.1016/j.aucc.2015.07.003
 15. Larizadeh MH, Malekpour Afshar R. Assessment of knowledge of cancer patients referred to Shafa hospital of Kerman about their disease. *Respiratory Medicine and Research Journal*. 2007; 31: 85-90.
 16. Khalil RB. Attitudes, beliefs and perceptions regarding truth disclosure of cancer-related information in the Middle East: a review. *Palliative & supportive care*. 2013; 11: 69-78. doi: 10.1017/S1478951512000107
 17. Ranjan P, Kumari A, Chakrawarty A. How can doctors improve their communication skills?. *Journal of clinical and diagnostic research: JCDR*. 2015; 9: JE01. doi: 10.7860/JCDR/2015/12072.5712.
 18. Gholami Baroughi S, Ravanipour M, Jahanpour F, Bayandari F. Nursing students and conveying bad news to patients. *Iran Journal of Nursing*. 2018; 31: 17-27.
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