

ORIGINAL ARTICLE

Practices, Attitudes of Doctors and Patient's Perspectives Regarding Breaking Bad News at a Tertiary Health Centre

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ABSTRACT

Introduction: Breaking bad news using SPIKES protocol will help effective bad news delivery to the patients. Assessing doctor's practices and attitudes in bad news delivery and exploring patient's perspectives on how bad news was delivered to them could give information about doctors' communication with patients. This study aimed to assess doctors' practices and attitudes of breaking of bad news and explore patients' perspectives.

Methods: The authors did questionnaire based qualitative and quantitative cross sectional study at a tertiary health centre in Nepal. They asked 75 doctors from various departments regarding their practices of breaking bad news as per SPIKES protocol. They inquired the same number of patients/relatives about how the bad news was broken to them. Practice scores among doctors were analyzed. The response of patients were compared with the doctors'.

Results: MD residents and doctors from Pediatric ICU/Neonatal ICU had better practice scores than Medical officers and doctors from Emergency department respectively. Consultants felt more confident in breaking bad news. Eighty four percent of the doctors wanted to deliver the bad news to the family members first than the patient. Most of the doctors believed they broke bad news as per the SPIKES protocol. However, as per patient's perspectives they were not delivered the news as per the protocol.

Conclusion: Most of the doctors agreed to practice breaking bad news as per SPIKES protocol and felt confident in doing so. There was a discrepancy regarding patient's perspectives and doctor's practice in how delivery of bad news was done.

Keywords: Breaking Bad News, Doctor-patient relationship, SPIKES protocol

INTRODUCTION

Breaking bad news (BBN) to the patients is a challenge that doctors go through every day. As a guide to physicians to break bad news, SPIKES protocol was proposed which consists of setting (S), patient's perception (P), patient's invitation (I), knowledge (K), empathy (E) and summary (S).¹ Ninety-nine percent of doctors regarded SPIKES useful.¹ BBN training enhanced the BBN skills in medical students.²

In a study done among Emergency Medical Staffs, 89% were unaware of any formal BBN

procedure and 58% had not participated in any training. Only a few participants were aware about SPIKES protocol.³

This study aimed to find out how the doctors practice BBN and also how they are following SPIKES protocol. This study also explored the patients' perspective towards how the bad news was broken to them. Due

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to lack of sufficient studies on practices of bad news communication of doctors in Nepal, this study can be helpful in knowing the scenario.

METHODS

The study was a questionnaire based quantitative and qualitative cross sectional study done at a tertiary health centre in Lalitpur, Nepal. Doctors from Medical Intensive Care Unit (MICU), Surgical ICU(SICU), Paediatric ICU(PICU), Neonatal ICU (NICU) and Emergency Department were taken as the samples because these departments mostly dealt with sick patients. All the doctors in these departments were approached in order to involve everyone in the sample size as per the recommendation by IRC. However, from the response rate, total sample size of doctors was 75 as only these number of doctors responded. For doctors, a validated questionnaire based on the SPIKES protocol was used and it was obtained with permission from another similar previous study in Oman⁴ and validated for this study's context with an expert in medical ethics at the hospital.

Data collection was questionnaire based in which the standard questionnaire was given to the

doctors that contained explanation about the study as well. They were assured a full confidentiality and a written informed consent was taken. The questions were subjected to a four point Likert scale (strongly agree, agree, disagree, strongly disagree). The data was entered into the computer using Epi info and Microsoft Excel. For the purpose of analysis of doctors, the total score was computed as follows: Strongly Agree- 4, Agree-3, Disagree-2 and Strongly Disagree-1. Mean Practice scores were calculated and confidence interval was calculated and it was seen whether there was significant difference or not. Attitudes of doctors were compared and put into themes as per the answers.

For patients' perspectives, the patients from same department were taken as samples. For patients admitted in intensive care units, their first degree relatives were interviewed. For patients in emergency, either patient or their visitor who were their first degree relatives were interviewed. In patients' perspective too, the equal number of patients were taken from each department same as the number of doctors. The number here was taken 75 as well because the doctors' sample size was 75. For patients', an already

validated questionnaire that assessed breaking bad news from patients' perspective in India was taken.⁵ Questionnaire was translated to the Nepali language and back translation was also done. Data was collected from direct interview based on the questionnaire. Responses were noted and expressed as numbers and percentages. The results were presented in tables, graphs and diagrams.

Study approval was obtained from the Institutional Review Committee (IRC) of PAHS (Patan Academy of Health Sciences). Consent was obtained from all participants. For written consent, generic PAHS format in English and Nepali was used. Participants could withdraw from the study at any time without giving any reason during the study period. The authors guaranteed confidentiality of the research participants with data in password coded laptop which could be assessed only by the principle author.

RESULTS

Table 1: Practice scores as per the gender, age, specialty, and qualification

Items		Mean +/- SD practice scores	Confidence interval
Gender	Male	32.13 +/- 3.33	31.121-33.151
	Female	33.06 +/- 2.23	32.219-33.919
Age Group	25-29	32.33 +/- 2.91	29.487-31.179
	30-34	33.80 +/- 1.93	32.729-34.871
	35-40	31.83 +/- 4.91	26.675-36.991
	40-44	30.75 +/- 2.62	26.581-34.919
Departments	MICU	32.50 +/- 2.67	30.26-34.73
	SICU	32.23 +/- 2.86	30.03-34.42
	PICU/NICU	35.44 +/- 1.87	34-36.88
	Emergency Department	31.94 +/- 2.96	30.98-32.9

Qualification	Medical Officer	31.64 +/- 2.88	30.68-32.6
	MD Resident	34.50 +/- 1.84	33.639-35.361
	Consultant	32.00 +/- 3.24	30.274-33.726

As seen in Table 1, there is no significant difference between the practice scores as per gender and age group. However, it is seen that there is statistically significant difference of practice scores between the Medical Officers and the MD Residents. Similarly, there is lower score in the age group of 25-29 which is statistically significant than age group 30-34. Similarly, there is statistically difference between the scores of doctors of PICU/NICU and Emergency department.

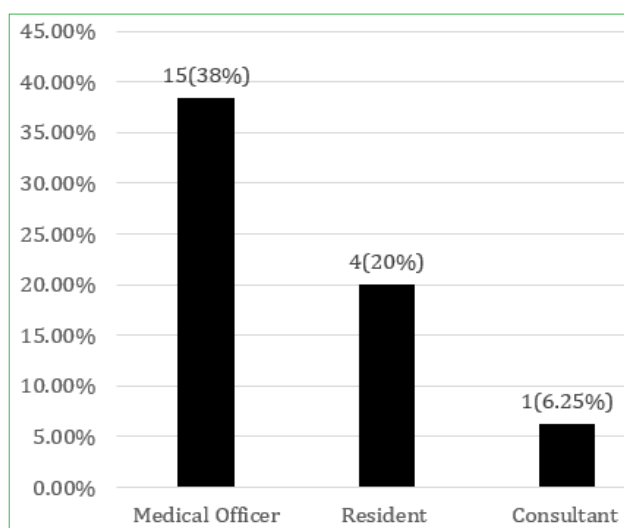


Figure 1: Respondents who try to avoid breaking bad news

Figure 1 suggests that out of total respondents, 15 (38.4%) of the Medical Officers tried to avoid breaking bad news whereas that number is 4 (20%) in residents and 1 (6.25%) in case of consultants.

Sixty-three (84%) of the respondents preferred telling the bad news to the family of the patient first and the rest 12 (16%) preferred telling the news directly to the patient as per Figure 2.

As per our study, 13 (81%) of the consultants felt confident in breaking bad news. This number was 10 (50%) in case of Residents and 19 (48%) in Medical Officers as shown in figure 3.

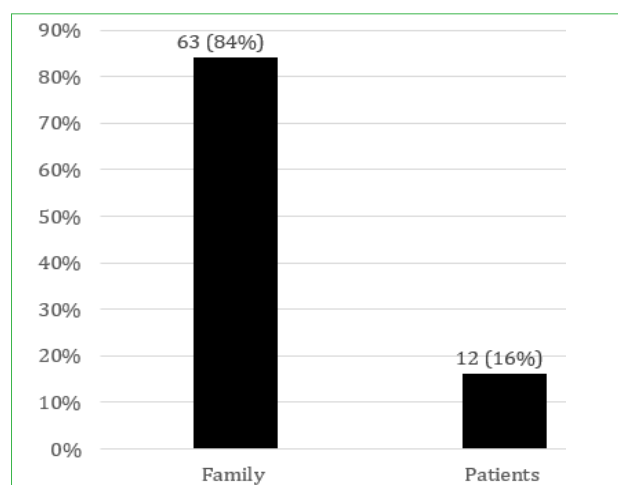


Figure 2: Preference of telling bad news to the family

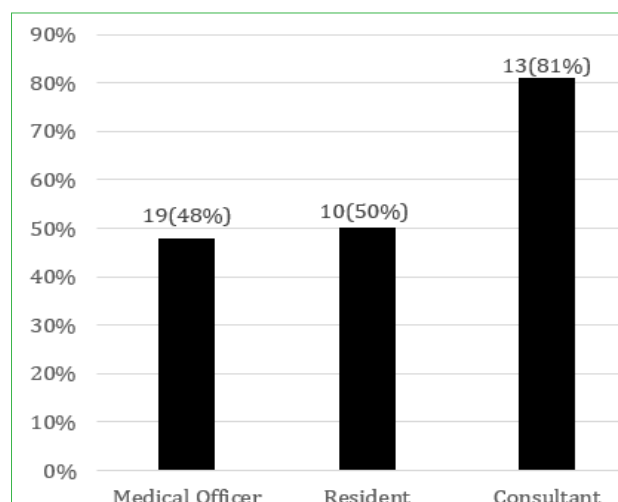


Figure 3: Respondents who feel confident in breaking bad news

Below are the results that shows how the patients perceived the breaking of bad news by doctors to them.

Table 2: Age group of Respondents of Patient's perspective

Age Group	Number
21-30	18
31-40	17
41-50	15
51-60	11
61-70	12
71 and above	2

The age group of respondents from patient's point of view is shown in Table 2.

Table 3: Frequency and Percentage of Response from Patient's Perspective

Response	Frequency	Percentage
Preferred a doctor of the same gender as them	1	2%
They were asked if they wanted a relative with them	15	20%
Doctors did not greet the patient	49	67%
Doctors did not speak in a language which patients could understand	2	3%
Doctors broke the news suddenly	38	52%
The patient/family wanted to know what the disease would do in their body	52	71%
Doctors outlined treatment options available to the patient	55	75%

From Table 3, we can see that as from the perspective of patients, only 2% of the patients preferred a doctor of the same gender as them. 49 (67%) patients said that their doctors did not greet them before delivering bad news. Similarly, only 15 (20%) said that the doctors asked them if they wanted a relative with them. Most of the patients (97%) told that the doctors spoke in the same language that the patient and their family members could understand. Almost half of the patients told that the doctors broke the bad news suddenly without giving them warning shots. Fifty two (71%) of the patients told that they were asked if they wanted to know what the disease would do in their body. Seventy five percent of the respondents told that the doctors outlined treatment options available to them.

Table 4: Comparison table between the doctors and patients

	Doctors n (%)	Patients n (%)
Break news in a private setting	70 (94%)	17 (23%)
Have a relative with the patient	70 (94%)	15 (20%)
Ask how much the patient wants to know about the disease	73 (98%)	19 (26%)

Give warning shots before telling the news	66 (88%)	35 (47%)
Give hope about the disease	60 (80%)	42 (56%)

As we can see in Table 4, 94% of the doctors said that they broke bad news in a private setting, however, only 23% of the patients told that the doctors delivered the news in private setting. Similarly, 94% of the doctors said that they had a relative with the patient before delivering bad news. However, only 20% patients told that the doctors asked for a relative to be with them or not. Seventy three (98%) of the doctors told that they asked the patient how much he wanted to know about the disease. However, only 26% of the patients told that they were asked if they wanted to know about the disease or not.

Again from Table 4, 88% of doctors said they gave warning shots before telling the real bad news, however, only 47% of the patients told that they were given warning shots before delivering the actual news. 80% of the doctors said that at the end of the session, they gave some hope to the patients, however only 56% of the patients told that the doctors gave some hope to the patients after the delivery of bad news.

DISCUSSION

As per our result, it was seen that the difference in practice scores between the MD Residents and Medical officers were statistically significant. It showed that the residents are more aware regarding the steps of SPIKES protocol to be followed while breaking the bad news. The reason for this may be because the residents have been trained and given lectures regarding the steps of breaking bad news. This fact is further enforced by the data that the age group 25-29 had statistically significant lower scores than the age group 30-34. This is in contrast to the previous study in Oman in which junior doctors with lower qualification had better scores than their senior counterparts.⁴ The doctors in the emergency department had statistically lower scores. This may be because most of the doctors in the emergency department were of medical officer level and as we saw earlier, medical officers had lower scores than their senior doctors. There was no difference in practice scores regarding gender. Hence, males and females equally participated in the stepwise delivery of breaking bad news.

In another question, when the doctors were asked whether they avoided breaking bad news, 38% of

the Medical Officers said they avoided the bad news, whereas that percentage was 20% in residents and 6.25% in consultants. The main reason why the physicians avoided breaking bad news was that they lacked experience. It was reiterated in the qualitative analysis in which experience was the main theme which determined whether doctors avoided breaking bad news or not. Upon asking the physicians whether they would prefer breaking bad news to the family members or to the patient directly, 84% of the respondents said they preferred breaking the news to the family first and only 16% of the physicians said they break the news to the patient first. This is in contrast to the study by Gongal et al in which 80% of the patients wanted to know the diagnosis.⁶ However, there are various reasons for this. One is the cultural aspect in which we in south Asia are culturally patriarchal where male, senior or the most educated members of the family take major treatment decisions. However, this trend has been changing since in a study in Japan, likelihood of doctors delivering bad news to patients and family members (as opposed to family members only) at the end of life increased from 2006 to 2012.⁷

In a study done in the hospital of Masshad (city of Iran), it was shown that 81.4% of doctors agreed on giving the bad news in private, while that number was 95% in this study. In that study, 72.9% agreed on giving relative hope to patients, the percentage was 75% here in our study. Lastly, in the Iranian study, 67.1% agreed on evaluating patient's knowledge of his/her disease when giving bad news.⁸ that percentage was 98% in this study. This means that almost all physicians at this centre assessed knowledge of the patients or their family members before delivering the bad news.

As per the patients' perspective, 67% of the respondents said that the doctors did not greet them. In a study done in the United States, 78% of the respondents wanted the physicians to shake their hand and 50% wanted the doctor to use their name while greeting them.⁹ but our study found that more than half doctors were not greeting the patients. There was no gender preference in the priority of physicians by the patients or their relatives.

Seventy-one percent of the patients and their families wanted to know what the disease would do in their body. Though the education level of the respondents may not be very high and though many of them might be illiterate or just literate, they still wanted to know

what the disease would do to their body and what happens to their body. Many times, the physicians often overlook this fact and just tell them their diagnosis and treatment plans, but the study shows a different picture. According to the patients, most of the doctors (75%) outlined treatment options to the patient. Patients expected these options to be available to them as a part of their treatment as they too wanted to be the part of their health management.¹⁰

When the results of doctors and patients were compared, there was a stark difference between what the doctors said they practiced and what the patients or their families said the doctors did. May be the doctors were not completely sure of their answers or practices or may be the patients and their visitors did not consider or notice the gestures or things that was done by the doctors. May be the doctors did not actually answer what and how they really practice.

In a study in Germany too, patients' preferences differed significantly from the way the bad news were delivered to them.¹¹ So we can see that just relying on one side of the doctor-patient spectrum does not give us the actual picture. If we had taken the data only from the doctors, then our result would've been skewed towards all the steps being followed by the doctors in terms of the SPIKES protocol. However, we surveyed the patients and their relatives as well and found that many of the doctors did not follow these steps. In Barnett M. et al, the patient's perception on breaking bad news by the doctor was that 69% of the patients were neutral or positive about the bad news consultation, but 20% were negative and 6% very negative.¹² In Sobczak et al, there were various aspects of delivering bad news that was lacking in doctors and they were doctor's behavior at the moment of breaking bad news, amount of time devoted to the visit, lack of doctor's attention, usage of medical terminology, honesty and emotional and cognitive support.¹³

In our study too, as per the patient's perspective, the aspects in which the doctors did poorly was not having a private or separate space while delivering bad news (23%). Similarly, the patients were not asked if they would like to have or not have a relative with them (20%) and the patients were not asked whether they would like to know what the disease did to their body (26%). In our qualitative analysis, it has been found that the main theme about doctors trying to avoid bad news was that they lacked "experience". In Bailey et

al, lack of experience from observing other clinicians in breaking bad news was one of the factors too.¹ However in a study in Oman, junior doctors were found to feel more confident than their senior counterparts.⁴ As for the attitude of breaking bad news, the answers were compared and put into themes. Most of the doctors who tried to avoid bad news stated that they didn't have the "experience" of breaking bad news. The common theme here was "experience".

In the question about whether breaking bad news should be done by the most senior member

of the treatment team or not, most of the respondents said yes and the reasons were "experience" of the senior member and "trust" towards the senior doctor. Hence, the common theme here was "experience" and "trust". Among the doctors who said they felt difficulty in breaking bad news, their main reason was fear of patient's reaction.

In another question, the reason why doctors felt difficult to break bad news, the answer was "Fear of reaction from the patient". This aspect was reiterated in another similar study as well.⁴ This is something that physicians have to learn to cope with as they will be facing variety of reactions and emotions from patients and their family members, like, anger, sadness, happiness etc and doctors have to learn to express empathy and deal with the emotions in a right way. So though the physicians' scores have shown that they did follow the steps as per the SPIKES protocol for breaking bad news, these figures are not something we can rely upon. The same questions to the patients and their families depicted a different picture regarding how bad news was broken to them by the physicians.

This study is not a perfect study and the limitations must be addressed. The doctors that have been in the study are not inclusive of all the doctors in the hospital as all of them could not be involved in the study due to their lack of response and also the time factor. Some medical officers may be new recruits with lack of experience of breaking bad news and some may have one or two years of experience with enough practice of delivering the news. So even though their data was generalized but it may not be a true representation. Similarly, in terms of patients and doctors' comparison, the data was not taken from the same set of patients with whom a particular doctor delivered the bad news. So a doctor may say he might have broken a news in one way but since it's not the same patient from whom

the data was taken, the patient may say he was given the news in another way. Similarly, many patients were from the emergency and in emergency there is not a separate private space and sometimes due to overload of patients, the physicians only counsel patients the main points about diagnosis and treatment. In these situations, even if the physicians wanted, they would not be able to break the bad news effectively following all the steps. Incorporation of Breaking Bad News training as per the SPIKES protocol in the medical education program may aid in enhancing this skill, as bad news delivered improperly and hastily can make a significant impact in patients and their family's mind throughout their lives.

CONCLUSION

This study concludes that most of the doctors agree to practice breaking bad news as per SPIKES protocol and feel confident in doing so. However, there is a discrepancy regarding patient's perspectives and doctor's practice in how delivery of bad news is done. Hence the doctors should introspect the way they are practicing and make necessary changes in their attitudes and communication skill.

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