ORIGINAL ARTICLE

Breaking Bad News - A Qualitative approach to explore Doctor's perspectives and experiences in tertiary care hospitals

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ABSTRACT

This qualitative study explored the Doctor's perspectives, experiences and practices in relation to breaking bad news (BBN) to patients or relatives/attendants.The bad news is defined as one which is pertaining to a situation where there is 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 individual fewer choices in his or her life. In this phenomenal qualitative approach, we collected data from a tertiary care hospital by focus group discussion. The sample size was 30 doctors with 1-8 years of working experience in the hospital. For less experienced doctors it was difficult to break the bad news but with experience, they found it relatively easier. Doctors explored that it was difficult to break news about young patients and children as well as too uneducated people. It is difficult to break due to an inappropriate setting and strategy. It's not a divine force; we can learn it by improving our communication skills. This study provides an insight into a range of different strategies and coping skills using by the doctors (junior and seniors both) in relation to BBN. The results reinforce and refine the imperative for further training to address the impact of BBN from the doctor's perspective if the performance of this critical task is to be improved.

Keywords: Breaking Bad News, qualitative study, Doctor's experience

INTRODUCTION

Bad news are any information that is likely to alter drastically a patient's view of his or her future, whether at the time ofdiagnosis or when facing the failure of curative intention. Naturally, how bad is a bad news depends onthe patients and family's expectations at that time, their level of illness, what medical Doctor feels about patient's health status, and on whether or not they already know or suspect theirdiagnosis or current state(Buckman, 1993).

While Science and Technology has excelled in every field of life, it can also minimize communicationgap between health care seekers and providers in hospital. Moreover,in this modern and sophisticated era of medicine, medical professionals and health technology isbecoming multifaceted butpivotal role is the treatment of disease,while no attention is being paid toward other significant sides such as person's feeling or emotions and behavior at bad situations(Davenport & Schopp, 2011; Rabow & Mcphee, 1999).

It's crucial to know about communication skills. The most important duty of doctors is to make it sure,that patients should be aware of everything about their condition or disease and keeps his/her autonomy in decision making. It is imperative to learn effective communication skills in order toovercome the psychological agony, solve patient's problems and convey realistic expectation to the client (Atienza-Carrasco, Linares-Abad, Padilla-Ruiz, & Morales-Gil, 2018; Cohen, 2003).

Hippocrates advised concealing most things from the patient while you are attending to him and give necessary orders with cheerfulness and serenity revealing nothing of the patient's future or present condition (Abdullah et al., 2012; Jones, 1923). There are many models that can be helpful in breaking bad news. Baile et al proposed a protocol called SPIKES model that can be followed while delivering bad news. The Six-Step Protocol for Delivering Bad News is SPIKES: S for setting up the interview, P is assessing the patient's perception, I for obtaining the patient's invitation, K is giving knowledge and information to the patient, E is addressing the patient's emotions with empathic responses and S for strategy and summary(Azadi, Abdekhoda, & Habibi, 2018; Baile et al., 2000). Rabow and McPhee also proposed another model for delivering bad news called ABCDE, as A is advance preparation, B isbuilding a therapeutic environment or relationship, C is communicated well, D for deal with patient and family reactions and E for encourage and validate emotions(Dyer, 2001; Markowitz & McPhee, 2006; Rabow & Mcphee, 1999). One more proposed protocol for breaking the Bad News is Breaks as B is Background, R for Rapport, E is to Explore, A for Announce, K is Kindling and S is to Summarize(Narayanan, Bista, & Koshy, 2010).

One of the most successful approach in breaking bad news is through client-centeredcounseling, as proposed by Karl Rogers. He putted forward three points to achieve a growth-producing therapeutic relationship between the client (the patient) and the counselor (the physician); these include congruence, unconditional positive regard and empathic understanding (C. Rogers, 1986; C. R. Rogers & Russell, 2002).

The medical education system in Pakistan is one of the largest in the world. It has a five and half year curriculum consisted on three-phase framework; pre-clinical, para-clinicaland clinical. Doctors are expected to takehighest responsibility of patients care during their clinical practices, including communicationand maintain

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privacy of patients and their family members(Nasim, 2011; Rajput, 2012).

Communication with patients regarding end-of-life matters a lot to all health care professionals, it is too common, howevershown to be associated with poor patient-care outcome(Evans, Gask, Singleton, & Bahrami, 2001; Hakim et al., 1996). Although there is some training in the West for medical students regarding breaking bad news but assessment of skills is not commonly done. In Pakistan, there is no formal training in communication for end-of-life issues, including breaking bad news(Evans et al., 2001; Nasim, 2011).

The main reason behind Physician's avoidance of the task of breaking bad news and reluctance to deal with the patient's feelings is lack of communication skills. In developing countries like Pakistan, only a few doctors receive formal training on BBN. Disappointingly current status of BBN in Health care system is questionable, this study attempted to address the latest perspectives of Doctors on BBN(Alelwani & Ahmed, 2014; Landa-Ramírez, López-Gómez, Jiménez-Escobar, & Sánchez-Sosa, 2018; van Zuilen, Caralis, & Granville, 2013).The objective of this qualitative study explored the Doctor's perspectives, experiences and practices in relation to breaking bad news (BBN) to patients or relatives/caregivers and to explore the phenomena why it is difficult especially for young doctors to break the bad news to patients.

METHODOLOGY

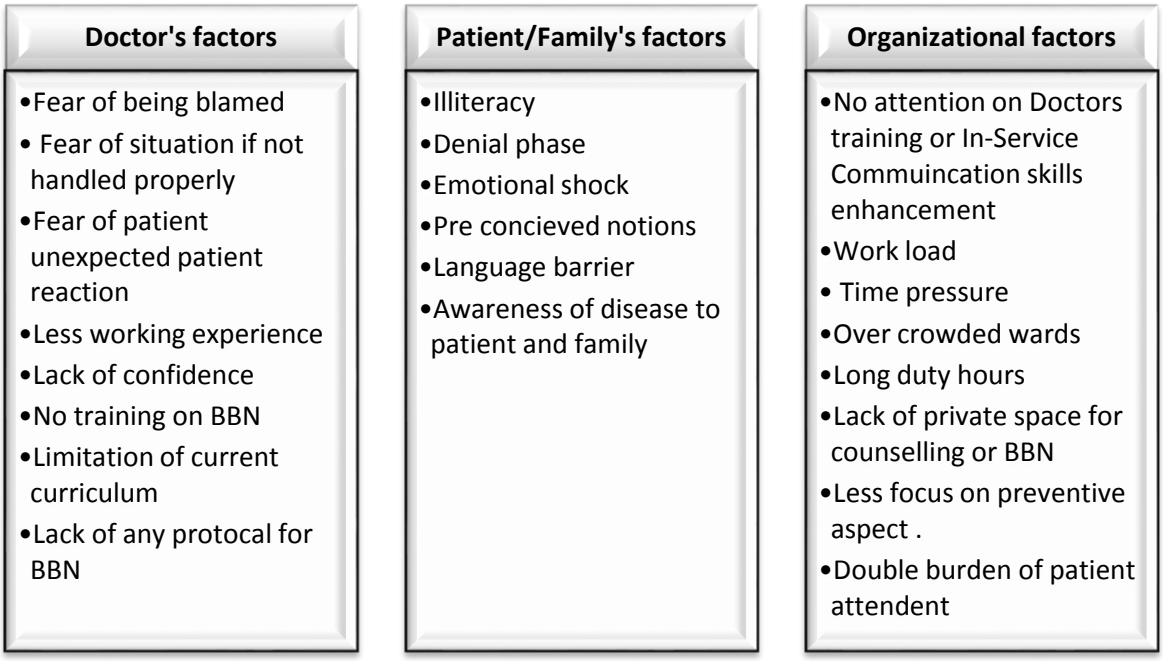
After consent from the hospital, we randomly selected Doctors with experience from 1 to 8 years working in a hospital setting. The study tool was focus group discussion withfive focused groups, six participants in each group. A guide for conducting focus groups was developed to explore doctor's' perspectives about communicating bad news. Data was kept confidential and anonymous. The doctors were informed at the beginning of the discussion that their perspectives would be used for a published paper and anonymity would be maintained.In order to enhance the creditability, we used audio recording after consent from participants.Focused group discussion time was set according to participants will.Responses were collected in English and Urdu language to address this sensitive topic effectively and audiotape.After training three researchers conducted focused group discussion, an open-ended questionnaire used to guide the participants. One researcher was asking open-ended questions, second was on the recording and to note facial expressions or any gesture related to the question, third was to keep control on the entire situation and keep the discussion on track. Three researchers independently transcribed audio tapped verbatim then comparative analysis by reading and rereading. An inductive content analysis of all the comments done. Categories of similar issues within the comments identified.Third person independent assessment of content done.

Qualitative data analysis was done usinga phenomenal approach with constant comparative analysis, a process of reading and re-reading the narrative data, developing categories of responses in the process, and then reviewing previously read data to check the appropriateness of the categories developed(Giorgi, 2012). Two reviewers independently coded transcripts and developed the categories. An inductive content analysis of all the comments was done. Categories of similar issues within the comments were identified and coded. The phenomenalapproach enables us to analyze the specific experience of Doctors(Starks & Brown Trinidad, 2007). Comparisons of category assignments were made between the two reviewers, and three interns who had participated in the focus groups did a member check to help ensure that the categories accurately captured all important issues. Coding procedure wasconsistent with Strauss and Corbin's open axial and selective coding principle.Initial coding of data was conducted by the lead researcher with an assessment of the coding strategies confirmed by others. All inconsistent finding were discussed until consensus was reached.Both similar and contrast views were considered to highlight the difference in doctors conceptualization of BBN. Coded data were analyzed to identify comprehensive themes, sub-themes and possible interrelationship. Doctors narratives provided a rich illustration of the main issue relating to BBN,and reflection,conveyed in doctor's own words,served to increase the validity of the study(Dey, 2003; Starks & Brown Trinidad, 2007; Strauss & Corbin, 1990). The issues, with illustrative quotes, are described in detail in the results section.

RESULTS

All participants described that BBN is a difficult task. Their experiences were varying from not that bad to very bad. It was difficult to break the bad news about young, child, male and acute condition respectively. BBN affects doctors emotionally, psychologically, mentally and few were affected physically also. Important factors leading to making BBN difficult according to this focused group discussions were shown in figure1.

Figure 1: Important factors leading to making BBN difficult



DISCUSSION

This study highlights the limitations of ourcurrent medical curriculum in helping medical professionals develop competence in communicating bad news, especially death-related. All doctors except oneillustrated that at the beginning they were uncomfortable with communicating bad news in these situations. The results of this study confirmed deficiencies in the curriculum, which may not be different from that of other medical universities in Pakistan, resulting in doctors being uncomfortable in communicating bad news. All doctors cited time constraints, overcrowding and lack of space and privacy as being the main institutional barriers. Inpatient factor they describe illiteracy and language is the main barrier. These factors make it difficult to appropriately delivery bad news and interfere with delivering health care, such as assisting family members as they view the deceased patient.

Findings from the study indicated that our Doctors are willing to learn communications skills in order to improve their clinical encounters. The study further supports the need for a formal curriculum in this area during the undergraduate level,House job as well asprofessional level. They felt that interactive sessions such as role-plays, one day workshops and feedback should be included in the curriculum to help them learn how to break the bad news.

CONCLUSION

One Doctor described that experiences of BBN improved with time. All Doctors in this study agreed that there is no protocol being followed in a hospital setting, BBN is totally scenario-based, varying person to person and case to case. They elaborated the following points that can help in BBN. Affectionate, kind words, sympathetic, empathetic, simple, easily understandable language, the lighter tone of voice. Sandwich approach, by informing alternative options and rehabilitation services. Never break news in a group, select one blood relation, mature and cooperative person from the group and explain all detailed situation in a private sitting area. Being accompanied by seniors helps in BBN. Participative approach, engaging patient's family members throughout the treatment process, bits by bits information on patient condition, repeating counselling sessions, spending more time and detailed information can make BBN an easy process.

Minor changes in a traditional curriculum with the integration of communication subject will help to overcome the problem. Raised the due status of communication subject in medical education. Workshops on effective communication skills at start of Doctors professional career. Decrease the working hours to improve it.

Research implications: Decision and policy makers at government level, medical institutions, hospital administration and stakeholders can use these findings to improve the situation of breaking bad news at both ends.

Limitations: The study does have some limitations. It was conducted at only one institution and included participants of the only section of the hospital. Experiences of professionals 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 skill as per modern criteria and to address needs and goals for communicating bad news to patients and families.

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