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BREAKING BAD NEWS: KNOWLEDGE, ATTITUDE, AND PRACTICE OF PHYSICIANS AT KING FAHAD SPECIALIST HOSPITAL-DAMMAM, SAUDI ARABIA

Medicine

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ABSTRACT

This study aimed to assess the knowledge, attitude, and practice of physicians in King Fahad Specialist Hospital-Dammam with regard to delivering bad news to patients and/or relatives. For this, a cross-sectional descriptive study was conducted among 150 physicians using a self-administered questionnaire. Our results found that 61.3% had good knowledge concerning delivering bad news, and 80% had above average attitudes. Meanwhile, with regard to who should be the first recipients of bad news, the majority of physicians felt that patients and relatives should be informed at the same time; further, 48% agreed to allow relatives to determine whether patients are fully or partially informed about the disease. Aside from these aspects, the practice of our physicians is consistent with the current guidelines. It is also notable that few physicians, 7.3%, update their knowledge through courses. Thus, training in this regard should be provided.

KEYWORDS

Delivering bad news, communication skills, Saudi Arabia

Introduction

"The patient will never care how much you know until they know how much you care." (Terry Canale, in his American Academy of Orthopaedic Surgeons Vice Presidential Address).

The rapid growth of the "patient-centered" approach to health care has highlighted the importance of high-quality communication skills. An area that remains problematic, however, is the process of delivering bad news (DBN) to either patients or their relatives, or both, and further research and training in this domain have previously been recommended (Dickson, Hargie, Brunger, & Stapleton, 2002). When patients visit a physician for a consultation about their health, they expect to actively participate in the decision-making process. However, to achieve this level of cooperation, many changes in the doctor-patient relationship are required. Traditionally, the physician has dominated decision making in terms of treatment, neglecting to consider the patient's feelings; however, the patient-oriented method advocates a more informed, shared, and negotiated approach, and this has been found to produce a more efficient decision-making process (Alrashdi, 2012).

In health care, bad news is defined as any serious, saddening, or significant information that negatively alters people's expectations or perceptions of their present or future (Fallowfield & Jenkins, 2004). The common denominator in bad news is the message given, as this has the potential to end hopes and dreams and inform patients that they will have to adapt to adverse lifestyles and face difficult futures. Examples of such messages include, but are not limited to: a) informing a patient that they have tested positive for HIV; b) informing a patient that they have Alzheimer's or Parkinson's disease; and c) informing a patient that a lump is malignant (Department of Health, Social Services and Public Safety, 2003). Further, similar messages are involved when notifying patients of illness recurrence, the failure of treatment, the spread of a disease, irreversible side effects, or the diagnosis of any other life-altering disease.

In general, most previous studies have shown that many patient complaints concerning physicians relate to poor communication, rather than clinical competency; patients favor physicians who can both successfully diagnose and treat their illnesses and communicate with them effectively (Ha & Longnecker, 2010). Addressing this issue may lead to the development of collaborative decision making, with physicians and patients participating as partners in an attempt to attain agreed plans and achieve good quality of life (Ha & Longnecker, 2010).

Further, much of the literature on DBN highlights that the manner in which such news is conveyed is crucial for encouraging patients to maintain hope and adapt to their situation, both instantly and in the long term (Randall & Wearn, 2005). Moreover, improved doctor-patient communication tends to increase the patient's involvement and adherence to the recommended therapy, influence their satisfaction and health care utilization, and improve the quality of care and health outcomes. Hence, it is clear that providing information in a manner that helps patients to cope with and understand what they are told requires skill, knowledge, and expertise (Fallowfield & Jenkins, 2004).

In the West, the recognition that many doctors may need further training to improve their communication skills has led to the establishment of training courses and workshops for undergraduate and postgraduate physicians on "how to deliver bad news" (Fallowfield & Jenkins, 2004). Many such training courses have proven effectiveness in DBN, and consequently these have been organized in hospitals worldwide, as mentioned in various research papers (Abel et al., 2001).

Another important development is the creation of guidelines on DBN and advice concerning good practice, which are designed to help health care employees when they are confronted with such a situation. In fact, a number of different clinical guidelines have been developed for the delivery of bad news; examples are the SPIKES model, which is a six-step protocol that consists of "Setting up the interview, Perception, Invitation, Knowledge, Emotions, Strategy and summary" (Baile et al., 2000), and the ABCDE protocol, which consists of "Advance preparation, Building a therapeutic relationship, Communicating well, Dealing with patient and family reactions, and Encouraging/validating emotions" (Rabow & McPhee, 1999). Key elements of all guidelines are the application of information that is tailored to the specific situation and patient, the exploration of the patients' perspective, and the ensuring of empathy for and understanding of patients' emotions and reactions (Storstein, 2011). Such guidelines are, in general, considered to be highly useful for planning difficult conversations and ensuring that vital issues are covered, although scientific evidence that this method improves patient satisfaction is quite sparse.

Literature Review

Physicians around the world treat millions of cancer patients every year. For example, in 2008, 12.7 million patients worldwide were newly diagnosed with cancer, and approximately 7.6 million patients died of this disease (12% of the total mortality worldwide) (GLOBOCAN, 2015).

In 2012, a review was conducted by Bou Khalil (2013) into attitudes, beliefs, and perceptions in the Middle East concerning truth disclosure of cancer-related information. In this work, a search was conducted using MedLine for all publications related to the review's objective, and this returned 55 publications, originating from Egypt, Israel,

Jordan, Kuwait, Lebanon, Palestine Pakistan, Saudi Arabia, Turkey, and the United Arab Emirates. Bou Khalil's results showed that, in the Middle East region, the diagnosis of malignancy is still mixed with misperceptions and social stigma related to feelings of hopelessness and incurability. This situation is compounded by the fact that many of these countries lack education programs that teach physicians effective methods of DBN. However, the most significant problem affecting truth disclosure to a patient who has cancer was found to be the lack of legislation concerning the patient's rights to informed consent. Considering this, it is clear that studies, legislation, and training programs relating to this topic are required in Middle Eastern societies.

Recently, in 2014, a review conducted in Saudi Arabia by Alewani and Ahmed (2014) showed that physicians' ability to communicate bad news to patients is concerning, but could not unequivocally prove that training of residents and medical students would be helpful for them to obtain the skills thought necessary.

Further, in 2011, Al-Mohameed and Sharaf (2013) conducted a study in the Qassim region of Saudi Arabia. The aim of this study was to explore physicians' perspectives and practices in regard to DBN. A total of 458 physicians, both from hospitals and primary health care centers, participated in the study, which involved the use of a self-administered questionnaire. Specifically, the questionnaire consisted of two sections: the first collected the physicians' characteristics, such as age, gender, specialty, qualification, year of graduation, clinical position, and work setting, while the second gathered data concerning their opinions and practices in terms of DBN. This latter section consisted of 23 items, which were primarily based on the main steps of the SPIKES model. As a result, the study found that physicians with higher qualifications scored lower than the mean in terms of DBN skills, while, in contrast, physicians working in primary health care centers were less reserved. The study also found that the majority of physicians (70%), preferred to discuss information with close relatives rather than patients, although over 90% of the study sample did report that they informed their patients about the bad news. Thus, the study found that the participating physicians were keen to help their patients, but that they lacked sufficient knowledge and skill to deliver bad news effectively. It should be noted, however, that this study was limited by its low response rate, which may give rise to sampling bias.

Another pertinent study was performed in Greece in 2015 by Konstantis and Exiara (2015). The aim of this study was to investigate the experience and education of medical personnel in terms of DBN; this was performed by distributing a questionnaire based on current guidelines, such as the SPIKES framework and the ABCDE mnemonic, to 59 doctors. The study consequently found that residents are involved in DBN less frequently than specialists, and that only 21 of the doctors (35.59%) had specific training in DBN. Meanwhile, 20 doctors (33.90%) reported that they were aware of the available techniques and protocols for DBN, and 46 doctors (77.97%) stated that they allowed relatives to determine how much information patients' were provided about their disease.

Another study was conducted in southwestern Nigeria in 2013 by Adebayo, Abayomi, Johnson, Oloyede, and Oyelekan (2013). This was a cross-sectional descriptive study conducted on doctors and nurses in two health care institutions; specifically, this study involved the use of an anonymous questionnaire (adapted from a survey developed by Horwitz et al., 2007) that covered training and awareness of DBN guidelines, and determined perceived competence by asking participants to use a 5-point Likert scale to assess five clinical scenarios. A total of 113 of the 130 respondents (response rate: 86.9%) were studied. Consequently, the study found that, despite showing high self-rated competence, a large proportion of this study's sample was unconsciously incompetent in DBN, with a low level of training in this regard and minimal or no knowledge of well-known protocols for DBN.

Studies have repeatedly shown that patients recognize good doctor-patient communication as a fundamental element of the quality of their health care. For example, a study conducted on 440 patients with either advanced cancer, heart disease, or chronic obstructive pulmonary disease (COPD) showed that 55.8% of the respondents cited trust and confidence in their physician looking after them as being extremely important to their care (Heyland et al., 2006).

Thus, it is clear that communication is one of the most important elements of end-of-life care, even more important than relief of symptoms (Heyland et al., 2006). Further proving this point, one study of cancer patients' preferences found that patients placed the highest priority on receiving information regarding their condition, ranking this higher than elements such as being comforted, reassured, or discussing their feelings regarding the news they received (Parker et al., 2001).

Another important point is that many physicians find DBN to be a stressful experience, even those who do this regularly. A survey of 700 members of the American Society of Clinical Oncology showed that over 75% of the physicians reported that they delivered bad news to a patient at least five times a month, with 45% of those doing so 10 or more times per month. However, despite this frequency, 39% rated their ability to deliver bad news as only fair, and 8% considered it poor. Further, 58% of all physicians in this survey identified "being honest but not taking away hope" to be the most challenging aspect of DBN (Baile et al., 2000).

Finally, it should also be noted that several studies have reported that physicians with inadequate training in communication skills are more likely to report high levels of distress and burnout than those who feel adequately trained (Ramirez et al., 1995), which clearly implies the importance of appropriate training in DBN.

Methods

For this research, a cross-sectional descriptive study was conducted at King Fahad Specialist Hospital-Dammam, a health care facility providing tertiary care in Saudi Arabia's Eastern Region, from January to February 2017. In particular, a self-administered questionnaire designed to elicit information on physicians' knowledge, attitude, and practices regarding the delivery of bad news to patients and their families was used. A total of 150 physicians were included in the study; physicians who were not in direct contact with patients, for instance, radiologists and pathologists, were not approached. All of the subjects volunteered to participate in the study; they then received a short, simply-worded, self-administered questionnaire written in English, with a covering letter explaining the project and the objectives of the study.

To design the self-administered questionnaire used to collect data in this study, we began by conducting a review of literature on this subject. Then, an initial draft of the instrument was piloted on 15 participants (equivalent to 10% of the total sample size) from another hospital, and this was followed by the modification of unclear items before the preparation of the final structured questionnaire. The pilot study was performed in order to ascertain whether the questionnaire was understandable and appropriate for the proposed study population.

Most of the items concerning knowledge and attitude, as well as physicians' practice, were adapted from Konstantis and Exiara's study (2015). Specifically, the questionnaire consisted of three sections:

- Questions concerning socio-demographic information (clinical position, age, sex, specialty, country in which the physician obtained their qualification, and years of experience).
- Questions to assess the knowledge and attitude of physicians regarding DBN. This consisted of eight questions, with yes/no responses required for all but two items.
- Questions to determine practice-related information concerning the main steps of DBN, especially regarding the SPIKES model and ABCDE protocol. This consisted of 13 statements, with the respondents using five-point Likert scales to indicate their degree of agreement with each, ranging from strongly agree, agree, uncertain, disagree, and strongly disagree.

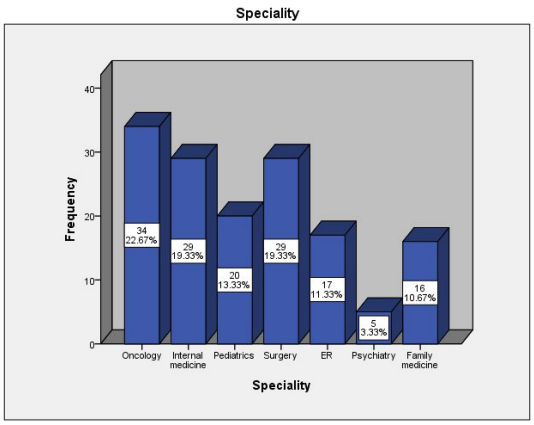
Upon completion, all questionnaires were coded and entered into an electronic database. For the purpose of analyses, the total scores for the practice-related questions were computed as follows: strongly agree = 5; agree = 4; uncertain = 3; disagree = 2; strongly disagree = 1. Meanwhile, knowledge variables were expressed using a summation of each variable and then developed into a 4-point Likert scale (0 = very poor, 1 = poor, 2 = fair, 3 = excellent) for three questions (where “yes” was given 1 point and “no” was given 0 points). Similarly, attitude variables were expressed using a summation of the variables and then developed into a 3-point Likert scale (0 = below average, 1 = average, 2 = above average) for two questions (where “yes” was given 1 point and “no” was given 0 points). Data analysis was performed

using SPSS version 21, and frequency distributions with numbers and percentages for all variables were produced. The questionnaire and the protocol were approved by the institutional review board of KFSH-D.

Results

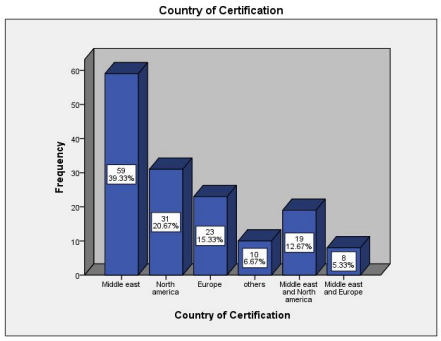
One hundred and fifty respondents (response rate 100%), compromising 105 (70%) male and 45 (30%) female physicians were studied; the average age was 43.1 years (SD 8.03; range 27 to 65 years). Twenty-three percent (22.7%) of the physicians identified their specialty as oncology, 19.3% as internal medicine, 13.3% as pediatrics, 19.3% as surgery, 11.3% as emergency medicine, 3.3% as psychiatry, and the remaining 10.7% as family medicine [Figure 1].

Figure 1: Physicians' Specialty (Percentage)



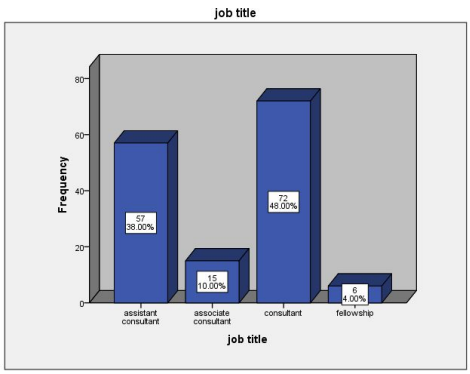
In regard to the countries in which these physicians obtained their qualifications, 39.3% received their degree from a Middle Eastern country; 20.7% North American; 15.3% European; 12.7% Middle Eastern and North American, 5.3% Middle Eastern and European, and the remaining 6.7% from Canada and South Africa. [Figure 2].

Figure 2: Country of Certification (Percentage)



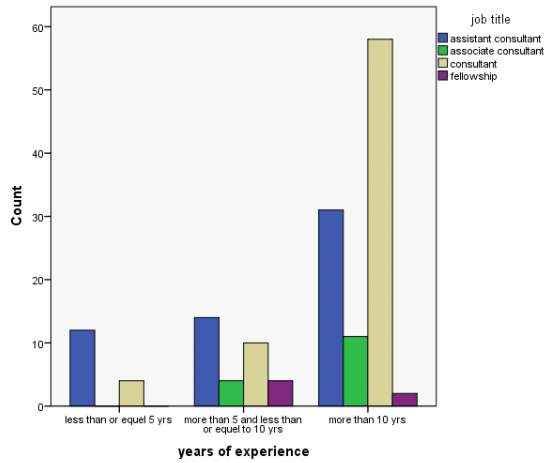
Approximately half of the physicians (48%) worked as consultants; this was followed in popularity by assistant consultants (38%) associate consultants (10%), and those who had fellowships (4%) [Figure 3].

Figure 3: Job Titles of the Physicians (Percentage)



Meanwhile, 68% had been practicing medicine for over 10 years, and 64 (42%) had delivered bad news over 10 times a year [Figure 4].

Figure 4: Physicians' Years of Experience (Percentage)



Further, approximately 57% (56.7%) of the respondents had received specific training in DBN; 50% of those had received training during post-graduate study, but only 3.3% had received it during undergraduate study. Approximately 53% (53.3%) reported that they had attempted to find out more information about this, with 7.3% of these using courses and the majority, 34%, using the Internet as the main means of updating their knowledge. Meanwhile, 61% (61.3%) of physicians had heard about guidelines and techniques on DBN, 80% stated that they had a consistent plan for DBN, and 70% answered that they did not deliver bad news in the same way for all patients.

Physicians' knowledge concerning the delivery of bad news is described in Figure 5, and physicians' attitude in Figure 6.

Figure 5: Knowledge of Physicians in Delivering Bad News

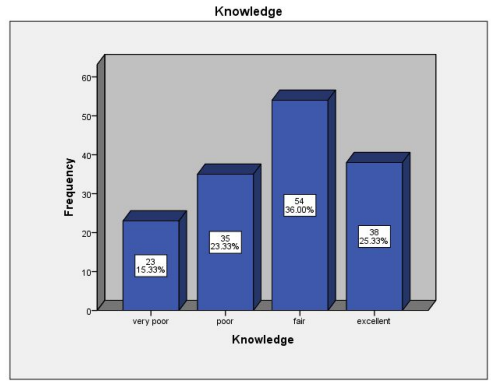
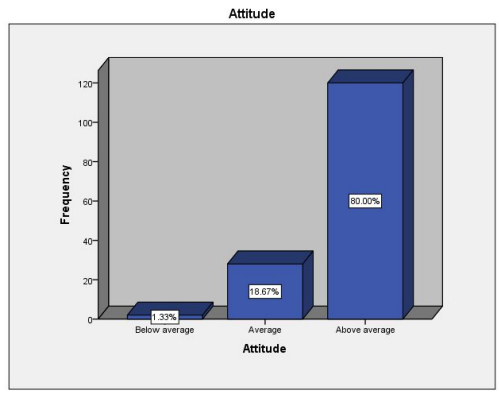


Figure 6: Attitude of Physicians in Delivering Bad News



Approximately 73% (72.7%) of the physicians stated that both the

patient and the relatives should be informed of bad news at the same time, while only 17.3% chose relatives as the first recipients. Moreover, approximately 33% (32.7%) of the physicians agreed, and 15.3% strongly agreed (giving a total of 48%), with allowing relatives to determine whether patients are informed fully or partially about the disease in question. However, 81% answered that they did try to convince relatives that the patient must know everything about the disease (Table 1).

Table 1: Frequencies regarding the practice of DBN to physicians

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
Bad news should be delivered to all patients in the same manner.	6 (4%)	26 (17.3%)	13 (8.7%)	69 (46%)	36 (24%)
Sufficient time and no interruptions should be ensured.	106 (70.7%)	43 (28.7%)		1 (0.7%)	
The medical file should be reviewed.	127 (84.7%)	22 (14.7%)	1 (0.7%)		
A quiet place should always be used.	125 (83.3%)	21 (14%)	4 (2.7%)		
Simple words should be used.	125 (83.3%)	24 (16%)	1 (0.7%)		
The physician should determine what and how much the patient should know.	73 (48.7%)	60 (40%)	11 (7.3%)	4 (2.7%)	2 (1.3%)
The physician should allow relatives to determine the patient's level of knowledge concerning the disease.	23 (15.3%)	49 (32.7%)	29 (19.3%)	38 (25.3%)	11 (7.3%)
The physician should generally try to convince relatives that the patient must know everything about his/her disease.	66 (44%)	56 (37.3%)	25 (16.7%)	3 (2%)	
Warnings should be given.	24 (28%)	48 (32%)	31 (20.7%)	21 (14%)	8 (5.3%)
Physical contact with the patient should be made when appropriate.	51 (34%)	64 (42.7%)	22 (14.7%)	9 (6%)	4 (2.7%)
The patient's understanding of the news should be checked.	96 (64%)	53 (35.3%)	1 (0.7%)		
The physician should be empathetic and respond to the patient's and their families' emotional reactions.	105 (70%)	40 (26.7%)	2 (1.3%)	2 (1.3%)	1 (0.7%)
Before the patient leaves the office, the physician should ensure that they have given him/her a follow up plan.	115 (76.7%)	34 (22.7%)		1 (0.7%)	

The study showed that, for all of the statements, there was no or a negligible correlation between the number of years of experience and the practice of DBN (the values lay between 0.01 to 0.19 and -0.01 to -0.19). However, a significant statistical association was found between training in DBN and giving a warning; that is, indirect, simple words delivered to the patient to prepare him/her for receiving the unwanted bad news (p-value = 0.001).

Finally, 98.7% considered training in DBN to be essential for their clinical practice.

Discussion

The goal of this investigation was to assess the knowledge, attitude, and practice of physicians in a tertiary care hospital, where the majority of physicians are confronted with difficult cases and discuss death or death-related disease on an almost daily basis.

Our study reveals that the majority of physicians preferred to inform both patients and their relatives of bad news at the same time. This concurs with the finding of Dhage and Wilkinson (2017), which found that all patients preferred to have their relatives present with them when they were about to receive bad news.

However, these researchers also reported that the presence of relatives might inhibit the disclosure of sensitive issues that patients wish to discuss. In family-oriented cultures, such as the Japanese culture, patients favor having their relatives with them much more than do patients from Western cultures (Peteet, Abrams, Ross, & Stearns, 1991). This is in contrast to the findings of previous studies conducted in Saudi Arabia (Al-Mohameed & Sharaf, 2013; Mobeireek, al-Kassimi, al-Majid, & al-Shimemry, 1996), where the majority of physicians prefer to discuss information with close relatives rather than the patients. This could be due to the fact that our physicians find it easier to share patient-related information with patients and families, as they work in a tertiary care hospital where numerous patients are newly diagnosed with cancer on an almost daily basis. In addition, cultures where family bonds are strong, such as the Saudi culture, tend to prefer a family-centered model of care. However, the Eastern Region in particular is more multicultural and educated than other parts of the country, and the people there attach greater importance to family bonds; thus, family-centered care is more strongly preferred in this region.

Moreover, approximately half (48%) of the physicians in our study agreed with the suggestion that relatives be allowed to determine patients' knowledge about the disease in question. A similar result was also found in a previous study conducted in Greece, where the majority of physicians allowed relatives to determine whether patients were informed fully about the disease (Konstatis & Exiiara, 2015). It is likely that this approach is a result of the prevalence of previous theories concerning patients' best interests (Holland, 1989). For example, “the Jewish view,” which exists in the USA, is that full disclosure of a fatal illness is a negative approach, as it may cause the patient to lose hope, suffer mental anguish, become despondent, and die sooner than they would have otherwise (Rosner, 2004). However, it should also be noted that 81.3% of our respondents answered that they try to convince patients' relatives that the patient has the right to know everything about the disease; this, in turn, could be explained by a rise in physician awareness concerning patient autonomy (Mobeireek et al., 2008).

In this study, 85 (56.7%) physicians reported that they had taken specific training in DBN, and most of them (75; 50% of the overall) had received it at the post-graduate level; this could be because medical schools have recently incorporated DBN into the undergraduate curriculum (Simmenroth-Nayda, Alt-Epping, & Gágyor, 2011). Moreover, many institutions have realized the importance of effective communication between physicians and have developed modern programs that give due importance to this skill.

Further, over half (53.3%) of the physicians reported having independently attempted to discern further information on methods of DBN, such as themes and techniques, and almost two-thirds of these stated that they used the Internet as the main source for updating their knowledge. Although the Internet is an efficient source for determining the core concepts of DBN, is easy to access, and can provide quick answers to concerns, it gives no opportunity for practice, discussion, and feedback, unlike training courses, which contain simulated patients and role play, thus providing the ability to practice DBN properly, a skill that can always be improved. A survey of hematology/oncology fellowship program directors in the United States showed that 63% of the program directors felt that extensive and formal training is essential for communication skills relating to DBN, and 23% reported that they had received moderate to extensive training (Hebert, Butera, Castillo, & Mega, 2009). The effects of such training are long lasting, but may require refreshing after many years in order to ensure that skills are not lost and that clinicians can continue to develop (Kramer, Ber, & Moore, 1987; Maguire, Fairburn, & Fletcher, 1986). This result may indicate that courses are not conducted routinely in this area, and efforts should be made to make such education available through workshops organized by professional trainers in communication skills.

Most physicians have a consistent plan, do not treat all patients in the

same manner, and focus on patients' perceptions and preferences. In other words, they behave in a manner that is consistent with the advice published in the medical literature (Ptacek & Ptacek, 2001). Most of the physicians in this study (61.3%) stated that they were aware of the latest guidelines and techniques, and in most cases that they select a quiet place, allocate enough time, use simple words, review the medical file before seeing the patient and his/her family, engage in physical contact when appropriate, and are empathetic and respond to the patient's and their family's emotional reactions. Moreover, after DBN, they ensure to give the patient a follow-up plan before they leave the office.

Some limitations to this study should be noted. First of all, the sample was relatively small and obtained from only one regional hospital, so no comparison was conducted between different hospitals. Secondly, in a tertiary care hospital where patients with cancer are in the majority, it is difficult to generalize the findings of this study to represent the general knowledge, attitude, and practice of physicians who work in primary and secondary care hospitals. Further research is required to study this important issue; a qualitative study would be particularly helpful for addressing this concern.

Conclusions

In our tertiary care hospital, the percentage of physicians with essential knowledge and awareness of the appropriate protocols and techniques concerning delivering bad news was found to be 61.3%, and 80% of these had above average attitudes. The majority of physicians stated that they felt that both patients and their relatives should be informed of bad news at the same time, while 48% of physicians agreed with the suggestion that relatives be allowed to determine whether patients are fully informed about the disease in question. Aside from these aspects, the practice of our physicians is consistent with the current guidelines.

Another notable finding is that approximately 99% (98.7%) considered that training in delivering bad news is essential for clinical practice. However, a low rate of physicians (7.3%) had sought to update their knowledge through courses. This suggests that efforts should be made in our hospital to arrange communication skills courses organized by professional trainers.

Finally, possible methods of improving the current situation include:

- The development and publication of regional guidelines.
- The development of a standard protocol for hospitals to ensure the delivery of bad news is performed professionally.
- The arrangement of regular meetings in hospitals with specialized professionals in order to facilitate the exchange of experiences and knowledge.
- The periodic staging of hospital-based training workshops in order to train physicians.

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