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Clinical nurses' experiences about "breaking bad news" during the COVID-19 pandemic: A qualitative study

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Abstract:

BACKGROUND: Nurses have the most contact with COVID-19 patients and their families, while it is unclear how nurses react when they give bad news during pandemic disaster, particularly in the cultural and social context of Iran. So, our main purpose was to explore the experiences of clinical nurses about breaking bad news (BBN) in the context of the COVID-19 epidemic era.

MATERIALS AND METHOD: The study was a qualitative content analysis approach. Data were collected by the purposive sampling method through in-depth interviews with 13 nurses in Isfahan University of Medical Sciences. The method of data analysis was conventional qualitative content analysis.

RESULTS: The participants of this study were 13 nurses. The work experience range was from 2 to 18 years, and in terms of education, one of them was Ph.D., eight had a bachelor's degree education, and four had a master's degree in nursing. Qualitative data of content analysis were obtained in four main categories such as nurses' avoidance of BBN, considering the patient's and family's beliefs in BBN, nurses' unpreparedness to deliver bad news during the pandemic crisis, and surrender of the patient and family members in the face of the COVID-19 bad news.

CONCLUSION: The results of the research showed that due to probability of occurrence of pandemic in the futureand also the nature of the nursing profession, so nurses should be familiar with the correct ways of BBN and existing protocols on crisis conditions and cultural and religious context of the society to provide a high quality of care for patients and their families.

Keywords:

Bad news, clinical, COVID-19, experiences, qualitative, nurse, Iran

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Introduction

Many situations are unfortunate and undesirable for hospitalized patients and their families, so that announcing them for patients is associated with a lot of stress and challenges for healthcare providers. Information that significantly alters a person's perception of his future in a negative way is considered bad news.[1] News related to the diagnosis of life-threatening diseases, progressive diseases, poor prognosis, failure in treatment, amputation, disease and treatment complications, and death is among the bad news.[2-4] In this regard, the patients' infection with the new respiratory disease coronavirus disease 2019 (COVID-19) is one of the bad news. The COVID-19 infection is a new disease that infects most people and kills a large number of them every day in all of the world.[5]

When caring for patients with COVID-19, healthcare providers, especially nurses, find themselves in challenging conditions including the psychological preparation of the patient and family for hospitalization, isolation and limitations of direct contact, and uncertain prognosis of the disease.[6] During

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the COVID-19 pandemic, most hospital departments have cared for patients with COVID-19 with low O2 saturation, need intubation, and rely on ventilators, cardiac arrest, coma, and unexpected death.[6] This puts nurses in a stressful position to breaking bad news (BBN) to their family members. In other words, nurses' role in BBN has changed with the coronavirus pandemic.[7]

It is important to recognize the cultural differences in BBN. In Iran, relations and emotions among family members are very strong. One of the most important bad news is delivering the news of the patient's death to family members. In these conditions, family members need the emotional and physical support of nurses. So, one of the most important communication skills required of Iranian nurses is the BBN.[8,9] Since nurses have the most contact with COVID-19 patients and their families, it is unclear how nurses react when they give bad news during pandemic disaster.[10] Furthermore, there are not enough studies on the experiences of nurses who deliver bad news during the COVID-19 pandemic, particularly in the cultural and social contexts of Iran. So, our main purpose was to explore the experiences of clinical nurses about breaking bad news (BBN) in the context of the COVID-19 epidemic era.

Materials and Methods

Study design and setting

This qualitative study was conducted with a conventional content analysis approach. It is a research technique for making replicable and valid inferences from texts (or other meaningful matters) to the contexts of their use.[11] The study was conducted at the university hospitals affiliated with Isfahan University of Medical Sciences. Eligible participants were nurses of various ages, work experiences, and educational levels, who had experienced care for COVID-19 patient. Nurses were selected through the purposive sampling method.

Study participants and sampling

Data were collected from September 2022 to March 2023 using in-depth, semi-structured, and face-to-face interviews. Interviews were focused on the experiences of nurses of BBN to COVID-19 patient and their family members and were held in the participants' preferred locations (either at their work or other else). The researcher asked the participants to describe what news is considered bad news during the COVID-19 pandemic. What are your experiences about BBN to the family members of COVID-19 patients? The length of time of the interview varied between 40 and 60 minutes, and the median length was 45 minutes. Data collection and data analysis continued until reaching data saturation, the point at which no new information or new categories result from additional data collection and analysis.[12] A total of 13 interviews were conducted.

Data collection tools and technique

In this study, the qualitative content analysis method of Granehiem and Lundman (2004) was used for data analysis.[11] All interviews were audio-recorded, transcribed verbatim, and then read through several times to obtain a sense of the whole. At first, researchers independently extracted all meaning units. Then, they discussed, and after resolving the discrepancies, they assigned codes to the condensed meaning units that were more abstract. Finally, initial codes were created and compared based on differences and similarities and sorted into subcategories and main categories. Confirmability, credibility, dependability, and transferability were used to assure various aspects of rigor.[13] Confirmability was established by registering and reporting various steps of the study. For data credibility, prolonged deep conflict with the data, peer inquiry, the review of the data, codes, subcategories and categories, and member checks were performed. To ensure dependability, a limited literature review was conducted at the beginning of the study to avoid bias during data analysis. To facilitate transferability, the researchers tried to explain the character of the research setting and the samples.

Ethical considerations

This study was approved by the Ethics Committee of Isfahan University of Medical Sciences (IR.MUI.NUREMA.REC.1401.071). All participants were informed of the objectives of the study and gave written consent.

Results

The participants of this study were 13 nurses. The work experiences range was from 2 to 18 years, and in terms of education, one of them was Ph.D., eight had a bachelor's degree education, and four had master's degree in nursing. Qualitative data of content analysis were obtained in four main categories and seven subcategories as listed in Table 1. Four main categories include nurses' avoidance of BBN, considering the patient's and family's beliefs in BBN, nurses' unpreparedness to deliver bad news during pandemic crisis, and surrender of the patient and family members in the face of the COVID-19 bad news.

Nurses' avoidance of BBN

One of the main categories obtained in this research is nurses' avoidance of BBN. Most of the nurses stated that during the COVID-19 pandemic had no desire to BBN to patients and their families. The increase in the number of deaths of corona patients, especially in intensive care wards, and the involvement of nurses in the emotional

Table 1: Categories and Subcategories of the nurses experiences about BBN

Categories	Subcategories
• Nurses' avoidance of breaking bad news	• Leave bad news to others • No participation in breaking bad news
• Considering the patient's and family's beliefs in breaking bad news	• Attention to the religious and spiritual aspects of the patient and his family in breaking bad news • Attention to communication among family members in conveying bad news
• Nurses' unpreparedness to deliver bad news during pandemic crisis	• Lack of communication skills • Lack of theoretical and practical preparation for breaking bad news by nurses during pandemic disasters • Lack of specific protocols for the nursing profession in breaking g bad news during a disaster
• Surrender of the patient and family members in the face of the COVID-19 bad news	

reactions of family members prevented nurses from BBN. According to the statement of the nurse: "*During the Covid-19 pandemic, the death of corona patients in the ward was a bad news for us and I didn't like to deliver this news to patients' family." (p1).*

Surrender of the patient and family members' encounter of the COVID-19 bad news

In this study, nurses stated that before the COVID-19 pandemic, families were resistant to accepting the news of their patient's death. During the COVID-19 pandemic, especially during the peak period of the disease, there was less resistance by family members to accept the bad news. It seems that they expected such news from the care team. According to the statement of the nurse, "*When the news of death was delivered to family members, the expectation of receiving bad news was clearly visible on their faces, and after hearing the news of their patient's death, they left the hospital in tears." (p12).*

Considering the patient's and family's beliefs in BBN

Nurses tried to consider the patient and family's past experiences and their various cultural, spiritual, and religious beliefs while BBN. Participant No. 9 said, "*When breaking bad news, I consider the patient's religious beliefs. I think that a patient's religious beliefs can help patient and their family members to accept the bad news better*."

Nurses' unpreparedness in breaking bad news during pandemic disasters

Another category was the lack of preparation of nurses in BBN during pandemic disasters. The subcategories included the lack of communication skills of nurses, the lack of theoretical and practical preparation of nurses for BBN during epidemic and pandemic crisis, and the lack of BBN protocols for the nursing profession during pandemic crisis. In this study, nurses emphasized that if they had the communication skills and different models of BBN, they can be BBN to patients or their families in a more efficient way. Participant number 7 stated that "*the training of braking bad news is not suitable for pandemic and pandemic crisis, and it is necessary to redesign the breaking bad news protocols for pandemic situation based on the cultural and social context of each country."*

Discussion

Nurses' avoidance of breaking bad news, considering the patient's and family's beliefs in breaking bad news, nurses' unpreparedness to deliver bad news during pandemic crisis, and surrender of the patient and family members in the face of the COVID-19 bad news were the main categories extracted in this study. Nurses tried to leave the task to the physician or social worker or head nurse, because they believed that the delivery of bad news is not the nurses' responsibility to do so. Other reasons for nurses to avoid breaking bad news during the COVID-19 period include the patient and family blaming them, fear of emotional reactions of patient family members, and a lack of knowledge regarding the cause, treatment, and prognosis of coronavirus disease. In the 2014 study by Abbaszadeh *et al*., (2014) nurses held the opinion that doctors should break bad news to their patients and it is not their task to do so.[14] In the study by Krieger *et al.* (2020), nurses stated that they did not want to tell patients bad or depressing news.[15] Delivering patient deaths to their families was one of the main sources of distress healthcare team in Jalili e*t al.*'s 2023 study.[16]

Surrender of the patient and family members' encounter the COVID-19 bad news was one of the study's categories, which helped nurses deal with patients who were less resistant to the bad news. The reasons for this were the increase in the patient's mortality rate during the peak period of the disease and the hospitalization of patients with severe respiratory failure in the intensive care unit and also the media's advertisements related to disease prognosis. In the study by Krieger e*t al.* (2022), the reactions of cancer patients before the COVID-19 pandemic were helplessness, disbelief and denial, anger and a sense of injustice, gratitude, and

depression.[16] During the COVID-19 period, the limited face-to-face communication with patients' families, limitation of communication with the patient due to personal protective equipment, the transmission of bad news over the phone, and families' fear of being in the hospital reduce emotional reactions such as anger, bargaining, denial in patients, and their family in the hospital environment. However, during the COVID-19 period the treatment team, especially the nurses, was unable to communicate effectively with the patient and their family due to the heavy workload.[17]

Considering the patient's and family's beliefs in delivering bad news was another category. In most of the guidelines, the cultural and religious dimensions of the patient in delivering bad news have been noted. In Abazari *et al*.'s (2018) study, the perception of bad news under the beliefs and attitudes, the development of protocols based on cultural context, and the training of healthcare teams about bad news have been emphasized.[18] In Iranian Islamic culture, it is important to pay attention to the patient and the family's beliefs in delivering bad news and not announcing the time of death. In Iran, due to cultural and religious contexts, most people prefer that the doctor does not talk about death while disclosing the diagnosis. Muslims believe that despite all the efforts of the healthcare team to treat and control the disease, life and death are almost entirely in the hands of God, who alone determines the time of death. Shahidi *et al*. (2010) also reported that almost half of Iranian patients with terminal illnesses were not aware of their diagnosis, and only one in six people was aware of their diagnosis, and none of them had a disclosure meeting with their doctor.[17]

One of the essential skills to deliver bad news is communication skill; therefore, the principles of effective communication with patients and their families should be carefully considered in times of crisis such as the COVID-19 pandemic. Also, nurses must manage stressful situations to support the patient and their family.[19] Most of the academic education and in-service education are not suitable for disaster and crisis conditions, and it is necessary to redesign the education for disasters in the future. In addition, it is a need to use virtual communication protocols in BBN. The limitation of this study was coordinating with the nursing staff for the time and place of the interview sessions, due to the high workload and the crowded departments. This led to the prolongation of the data collection time in the qualitative phase for about 6 months. The present study was conducted to evaluate clinical nurses' experiences about "breaking bad news in the COVID-19 pandemic era," and it is suggested that future researches design guidelines for delivering bad news in times of crisis for nurses based on Iran sociocultural context.

Conclusion

The results of the research show that due to the nature of the COVID-19 pandemic and also the nature of the nursing profession, there is an intertwined experience of facing this crisis, so nurses should be familiar with the correct ways of communicating in breaking bad news and existing protocols on crisis conditions and taking into account cultural and religious differences so that they can provide a high quality of care for patients and their families.

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Conflicts of interest

There are no conflicts of interest.

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