Original Research Article

Critical Care Nurses' Attitudes, Roles, and Barriers Regarding Breaking Bad News

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Abstract

This study examines critical care nurses' attitudes, roles, experience, education, and barriers regarding breaking the bad news. A descriptive, cross-sectional design was used in this study. A convenience sample of 210 critical care nurses completed the study. Most of the critical care nurses contributed to breaking bad news and they were involved in different roles in this process and they had a positive attitude regarding breaking bad news. In this study, (75.2%) of the participants reported that they did not receive any specific training regarding breaking bad news. In addition, nurses face various barriers when breaking bad news. Critical care nurses' involvement in breaking bad news should be encouraged. Most barriers to BBN were negatively associated with nurses' roles, attitudes, and experiences during BBN. Administrators should promote the involvement of critical care nurses in breaking bad news and strengthen them through addressing the challenges they face in the process of BBN.

Keywords

critical care nurse, attitude, role, breaking bad news

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Introduction

Breaking bad news is one of the most complex and difficult tasks for healthcare providers (Ozyemisci-Taskiran et al., 2017). Among all health care providers, nurses have important role in the process of breaking bad news, such as clarifying information for patients, providing emotional support, delivering bad news individually, and clarifying ambiguous words (Imanipour et al., 2016).

The critical care units (CCUs) have stressful and complex environment that can contribute to high levels of emotional exhaustion, stress, and anxiety for patients and their families (Al-Ajarmeh et al. 2021; Adams et al., 2015; Sharour et al., 2019). Bad news may include news about death, illness, or lifestyle changes associated with chronic illnesses such as coma, respiratory distress, diabetes, heart disease, and hypertension (Nicol, 2015). Nurses need to be confident in their skills at delivering bad news, and to achieve such confidence, adequate preparation and collaboration is required between nurses and members of the multi-disciplinary team, including social workers and physicians (Imanipour et al. 2016).

Review of Literature

The challenges faced by nurses when breaking bad news include the fear of being blamed by patients (Adebayo et al., 2013), the ambiguity of their role during the process (Kirby, 2016), and inadequate knowledge and preparation (Dewar, 2000; Rassin et al., 2006). Nurses also face such barriers as supporting patients from different cultures and caring for patients' emotions when breaking bad news (Sereshti and Izadi, 2013).

When bad news is delivered inappropriately, it may lead to confusion, anger, and anxiety in patients and their families (Back et al., 2007). If adequate effort has been made by nurses to assess and explore the patient's perception of the

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bad news given, the patient can better engage in further management of the disease (Rosenzweig, 2012).

Providing bad news does not necessarily lead to harmful or wholly negative responses in patients. It may, in fact, improve the patient's health and their relationships with the medical team (Atienza-Carrasco et al., 2018). Ineffective communication leads to stress and reduces patients' understanding of information related to their health status (Al-Husban et al., 2021). According to Imanipour et al. (2016), only 16.2% of nurses have a good level of knowledge about how to break bad news; thus, training programs should include practical and theoretical components to help nurses perform better in this area (Nickels & Feeley, 2018). Tien and Wakefield, 2018). Nurses who have positive attitudes toward breaking bad news may play a positive role in improving the emotional well-being of patients and their ability to achieve their therapeutic goals (Mishelmovich et al. 2016).

This review of the literature has presented various studies that have targeted nurses' attitudes, experience, roles, education, and barriers to breaking bad news. Most of the literature was from western countries, with few studies conducted in Jordan or other Arab countries. Each researcher used his/her own instrument, with no standard instrument to measure nurses' attitudes, roles, experience, education, and barriers to breaking bad news. Most studies related to breaking bad news have targeted doctors, while several have included nurses. There are gaps in the research with regards to the current experiences of nurses working in critical care, particularly from non-Western countries.

Most of the previous studies on breaking bad news consider it as the physician's rather than the nurse's duty (Mishelmovich et al. 2016). For example, Abbaszadeh and Ehsani (2014) mentioned that the doctor has the principal responsibility for breaking bad news.

The current study addresses the attitudes and roles of nurses in breaking bad news in EDs, CCUs, and ICUs in Jordan. The current study provides baseline information on the attitudes and roles of nurses when breaking bad news, which in turn will facilitate the development of intervention programs and policies that help nurses to deliver bad news to patients. This study addressed the following research questions:

1. What are the attitudes of critical care nurses towards breaking bad news?
2. What are the roles of critical care nurses in breaking bad news?
3. What are the experiences of critical care nurses in breaking the bad news?
4. What are the barriers to breaking bad news reported by critical care nurses?

Methodology

A descriptive, cross-sectional design was used in this study. The study was conducted in the largest government hospital in Amman-Jordan. The inclusion criteria were: being a registered nurse working in one of the following units: ED, ICU, or CCU. The estimated sample size was 233 participants, which included all registered nurses working in the above units.

Ethical Considerations

The IRB Approval for conducting this study was obtained from the Institutional Review Board at Al-Zaytoonah University. Before collecting data, permission was also obtained from the Jordanian Ministry of Health (Approval number: MOH/REC/2019/141). The researcher explained the study purpose to all participants and informed them that their participation in this study was voluntary and that they were free to withdraw at any time. The confidentiality of the information obtained from participants was also assured. All the completed questionnaires were kept in a secured office and only the research team was able to access them. All participants signed informed consent to participate in the study and confirmed their understanding of the study's purpose and procedure.

Instruments

The data were collected using the following instruments:

Demographic Information Form

The Demographic Information Form is a self-reported tool used to obtain basic demographic data on study participants, including their gender, age, marital status, employment status, and level of education, income, and duration working in the ED, ICU, or CCU. In addition to information related to organizational factors, such as whether or not the hospital cooperates with nurses who disclose bad news, participants were asked if the hospital has certain protocols for disclosing bad news, as well as other recorded statements related to breaking bad news.

Attitudes of Nurses Regarding Breaking Bad News

This tool has 27 items rated on a 5-point Likert-type scale (Mohamed, 2018), with scores for each item ranging from 1 (strongly disagree) to 5 (strongly agree), and attitude scores classified into poor attitude (<50%), fair attitude (50 to 65%), and good attitude (>65%). The tool was used in a previous research and permission to use it was obtained from the original author. In the current study the pilot testing shows that the tool had excellent internal consistency (Cronbach's alpha = 0.91).

Roles of Nurses in the Process of Breaking Bad News

This scale developed by Imanipour et al. (2016) and it contains five items rated on a 5-point Likert-type scale. The scores for each item range from 0 (never) to 4 (always). The scale had excellent internal consistency with a Cronbach's alpha about 0.86.

Table 1. Demographic Characteristics of the Participants (N = 210).

Variable	Mean (SD)	Range	N (%)
Duration of work in the current hospital	5.9 (3.81)	1–27	
Job Description			
Registered nurse			208(99.0)
Other			2(1.0)
Education			
BCS			183(87.1)
Master and PhD			27(12.9)
Income			
250-450 JD			80(38.1)
450-750 JD			114(54.3)
More than 750 JD			16 (7.6)
Working shift			
A			45(21.4)
B			18(8.6)
C			17(8.1)
All			130(61.9)
Place of current work			
Paramedic and ER			67(31.9)
ICU			108(51.4)
CCU			35(16.7)
Are you receive any course related to bad news disclosure?			
Yes			59(28.1)
No			151(71.9)
Have you ever disclosed bad news?			
Yes			148(70.5)
No			62(29.5)
If your answer was "yes" at any shift?			
A			16(7.6)
B			27(12.9)
C			13(6.2)
More than shift			92(43.8)
Had you watched a disclosure case among colleagues?			
Yes			178(84.8)
No			32(15.2)
If your answer was "yes" at any shift?			
A			21(10.0)
B			32(15.2)
C			16(7.6)
More than shift			109(51.9)
Is your organization cooperating with individuals who disclose bad news?			
Yes			65(31.0)
No			145(69.0)
Are there certain protocols for disclosing in hospitals?			
Yes			49(23.3)
No			161(76.7)

Nurses Experiences Concerning the Process of Breaking Bad News

Warnok et al. (2010) developed a questionnaire on nurses' experiences of breaking bad news. This tool consists of 12 items, with responses rated on a Likert scale from 1 (strongly disagree) to 5 (strongly agree). In this study, the scale had excellent internal consistency (Cronbach's alpha = 0.91).

Barriers to Breaking Bad News

This questionnaire focuses of six barriers to breaking bad news including: barriers of exploration, preparation, feeling, training, communication, and organizational characteristics. It was developed by Payan et al. (2009). The tool developer reported that the tool has satisfactory criterion validity (Payan et al. 2009). In this study, the scale had excellent internal consistency (Cronbach's alpha = 0.95).

Data Collection Procedure

After obtaining ethical approvals to conduct the study, the researcher contacted the head nurses of each unit to discuss the purpose of the study and to provide a brief description of the study protocol. All nurses in the ED, ICU, and CCU were initially selected, and the objectives and content of the questionnaire were explained to them. Eligible participants then signed the consent form and they were given a copy of the questionnaire to return it completed. Each questionnaire was given a code to achieve anonymity and placed in an envelope. Finally, a total of 210 completed questionnaires were returned, giving a response rate of 90.12%.

Data Analyses

The data were analyzed using the Statistical Package for Social Sciences (SPSS), version 23 to assess the Jordanian critical care nurses' attitudes, roles, experience, education, and barriers to breaking the bad news using descriptive statistics.

Results

Sample Characteristics

A total of 210 participants completed the study, giving a response rate of 90.12%. 117 (55.7%) participants were male and 93(44.3%) were female. The mean age for participants was 31.5 years (SD = 4.73), ranging from 22–49 years. One hundred and thirty-seven participants (65.2%) were married. The mean years of experience in nursing for participants was 7.8 years (SD = 4.42), ranging from 1–27 years. For more information see Table 1. The majority of participants (75.2%) reported that they didn't receive any training or education about breaking bad news, 17.6% received training for a full day and less, and only 4.3% received training more than one day.

The Attitudes of Critical Care Nurses Toward Breaking Bad News

The overall mean percentage of agreement with items that indicate a positive attitude toward breaking bad news was 80.65%, indicating an overall good attitude toward breaking bad news. Specifically, 16 (7.6%), 17 (8.1%), and 177 (84.3%) had poor, fair, and positive attitude, respectively. Items that had the highest percentage of strongly agree were "Doctors and nurses should consider the psychological status of patients while breaking the bad news (59.5%)," "Doctors and nurses should consider patients' religious beliefs while breaking bad (55.7%)," and "It is the patient's right to know everything about his/her medical condition (52.7%)." On the other hand, no one of the nurses strongly agreed on the item "physicians & nurses are the appropriate people to break the bad news (0%).

The Roles of Critical Care Nurses in the Process of Breaking Bad News

The average mean of involvement in breaking bad news process is 2.70 out of 4. The results of the current study showed that most of the Jordanian critical care nurses contributed to breaking bad news and they were involved in different roles in this process. The most three roles undertaken by nurses included: "Breaking bad news individually (2.83 $\pm$ 1.03)," "Explaining doctor's words in layman's language (2.77 $\pm$ 0.97)," and "Emotional support for patient and family (2.67 $\pm$ 1.02)" respectively. On the other hand, the roles that were carried out least often were "preparing patients and their family to hear bad news" (2.65 $\pm$ 1.03) and "helping patients and their family come to terms with bad news" (2.60 $\pm$ 1.04).

The Experiences of Critical Care Nurses Toward Breaking Bad News

The Mean score of the questionnaire = 3.74 (SD = 0.70). One response that had the highest score related to patients and their relatives was: "Being involved in the process of BBN can be rewarding as it can help the patient/relative prepare for the future". The response which had the highest score related to both (patients/relatives and nurses) was "Being involved in the process of BBN has strengthened my relationship with a patient/relative". While the response which had the lowest score related to both (patients/relatives and nurses) was "I find it difficult to deal with patient's/relative's emotional reactions to bad news". The response which reflected the highest score was "nurses felt that it encouraged them to reflect positively on their priorities and what is important in life". While the one response which reflects the lowest score was: "nurses tried to avoid being involved in BBN's because they find it difficult".

The Barriers of Breaking Bad News Reported by Critical Care Nurses

The overall mean score for Barriers of Breaking Bad News was 2.76 (SD = 0.64).

The total scores of items in each subscale were calculated and then divided by the number of items under each subscale to elucidate the mean subscale which ranges from 1 to 4. The higher mean indicates greater barrier (Table 2). Accordingly, the most reported barrier was training (M = 3.01, SD = 0.76), and the least barrier was feeling (M = 2.62, SD = 0.83).

The Relationship Between Roles, Attitudes, Experiences, and Barriers of Breaking bad News

Table 2 presents the relationship between the main study variables. The results indicate a significant positive relationship

Table 2. The Relationship Between the Main Study Variables.

		Attitudes	Roles	Experiences	Barrier1 Preparation	Barrier2 Investigation	Barrier3 Information	Barrier4 Feeling	Barrier5 Training	Barrier 6 Organizational	Overall Barrier score
Attitude	r		.291**	.664**	-.414**	-.294**	-.489**	-.300**	-.357**	-.209**	−0.517**
Roles	r	.291**		.356**	-.431**	-.391**	-.496**	-.042	-.352**	-.365**	−0.472**
Experiences	r	.664**	.356**		-.269**	-.309**	-.445**	-.268**	-.407**	-.341**	−0.491**
M (SD)		108.07 (13.71)	2.70 (0.80)	3.74 (0.70)	2.95 (0.57)	2.89 (0.69)	2.86 (0.55)	2.62 (0.83)	3.01 (0.76)	2.71 (0.76)	2.76 (0.64)

**Correlation is significant at the 0.01 level (2-tailed).

between attitudes and roles (r = .291, P < 0.01), roles and experiences (r = .356, P < 0.01), and experiences and attitudes (r = .664, P < 0.01). The overall mean score of barriers to BBN was negatively associated with nurses' roles (r = −.472, P < 0.01), attitudes (r = −.517, P < 0.01), and experiences during BBN (r = −.491, P < 0.01). In addition, most barriers of BBN were negatively associated with nurses' roles, attitudes, and experiences during BBN (Table 2).

Discussion

The current study examined nurses' attitudes, roles, feelings, and experiences in BBN and correlated them with perceived barriers faced while BBN. The study focused on BBN in critical care environments, with a sample from a non-Western setting.

Regarding nurses' attitudes toward BBN, 84.3% of the participants had a good attitude toward breaking bad news. This outcome is comparable with findings of previous work on BBN among nurses in other settings. For example, the study of Mohamed (2018) which examined nurses' attitudes toward BBN in the radiation therapy department found that 81.6% of nurses had a good attitude toward BBN. In another recent study conducted among physicians, the vast majority of physicians had positive attitudes towards breaking bad news (AlZayani et al. 2022).

An example of attitude items with a high percentage of agreement is "considering the psychological status of patients while breaking bad news". This finding is consistent with a study conducted on nurses who provide care for cancer patients (Arbabi et al. 2010), which highlighted the importance of paying attention to the patient's psychological status while delivering bad news. The same outcome was reported by Mohamed's (2018) study, in which nearly the same percentage of Sudanese nurses strongly agreed on the same issue. This similarity might be due to the similarity of nursing education in Arab countries, which emphasizes the importance of considering patients' psychological status. Another possible explanation might be nurses' belief that bad news may cause psychological fatigue and suffering from the disease, which necessitates caring for the patients' psychological status. Considering patients' psychological status was also highlighted by physicians. Van Osch et al. (2014) addressed the importance of considering patients' psychological status when BBN by physicians and found that negative patients' emotional reactions caused by the bad news can be reduced by physicians' affective communication.

Further, most participants strongly agreed that they should consider the patients' religious beliefs while breaking bad news. This is relatively close to the percentage of Sudanese nurses who strongly agreed on the same issue (Mohamed, 2018). This consistency might be attributed to the prevailing Islamic religion in the Arab world, that different religious beliefs should be respected. Furthermore, nursing schools in Arab countries consider patients' religious beliefs.

Abazari et al. (2017) reported that most people in Iran prefer that the physician not talk about death while BBN which may be attributed to religious beliefs of Muslims that death is completely in the hands of Allah, the only one who decides the time of death.

Moreover, most participants strongly agreed that it is a patient's right to know everything about his/her medical condition. Previous studies show the same result, including Arbabi et al. (2010), who found that both physicians and nurses preferred patients to know everything about their medical conditions and to consult the patient on treatment decisions related to their health status. Similarly, in Mohamed's (2018) study, Sudanese nurses strongly agreed that it is a patient's right to know everything about his/her medical condition. The same outcome was reported among physicians in Arab countries. For example, in a study conducted with 113 physicians in Bahrain, about 83% of the participants agree that all patients have the right to know their medical status and diagnosis (AlZayani et al. 2022). One possible explanation for this might be that nurses and physicians in Arab countries are well informed about patients' rights, as they have been instructed on these rights in their nursing schools. Therefore, one area of agreement to date is that informing patients is an ethical and legal right, while not giving news or concealing medical information related to the patient's condition may lead to a loss of patients' confidence in health care providers. When compared to a western study, health care providers highly value the right of patients to know about their serious diagnosis (McCabe et al. 2010). However, telling the truth is not preferable in all cultures. In China, for example, physicians tend to not tell the truth to patients with life threatening conditions like cancer (Ding, 2000).

Interestingly, none of the participants in this study strongly agreed that nurses and physicians are the appropriate persons to break bad news. This outcome was previously reported in the literature in Arab samples. For example, in Mohamed's (2018) study, more than half of Sudanese nurses strongly agreed on these issues. This might be related to nurses' belief that they are only obligated to provide care for patients and do not have time to conduct other tasks; they also believe that this task should be conducted by a specialist clinical psychologist and their lack of education compared to a psychologist made them avoid these tasks (Rassin et al. 2013). This outcome indicates differences between Arab and Western people in this regard. According to Salem and Salem (2013), patient's illness in Arab countries is a "family event" rather than "personal event" and family has a central role in decision making and BBN. On the contrary, in Western countries patient's illness is a "personal event" rather than "family event" and patient has the right to know bad news from nurses or physicians (Salem and Salem, 2013). The outcomes of this study are also opposite to Arbabi et al. (2010) who indicate that doctors and nurses are the right people to deliver bad news.

The average mean score of involvement in the BBNs process was 2.70 out of 4. This score is closely related to the scores reported by Imanipour et al. (2016) who reported the lowest mean score ($M = 2.19$) for "breaking bad news individually" and the highest mean score ($M = 2.81$) for "emotional support for patient and family". Breaking the bad news in critical care units is a complex task, which might require varied roles and nurses' contributions at all stages in the inpatient pathway, from diagnosis, through treatment and rehabilitation, to death. The role most often assumed by participants was the breaking of bad news individually, which is opposite to Imanipour and colleagues' (2016) findings. This result might be explained by the fact that nurses in the study sample often find themselves responsible for breaking bad news due to, workload, unexpected acute conditions, and insufficient time.

On the other hand, the role least often identified by participants is preparing patients and helping them to hear and cope with bad news, in line with Imanipour and colleagues' (2016) findings. This is related to a lack of privacy, knowledge, and time in critical care units, and weak communication skills to convey bad news to patients and their families. Fear may also be a factor that affects the process of breaking bad news to patients, consistent with the result of Rassin et al. (2013), who noted that nurses felt fearful of breaking bad news and made extra effort to avoid this task. However, it is inconsistent with other studies, such as those by Warnock (2014) and Warnock et al. (2010), which showed that preparing patients and helping them while breaking bad news was the most frequent role played by nurses.

The results of this study revealed participants' different experiences regarding their involvement in the process of breaking bad news. Most participants believe that being involved in this process can help patients/relatives to prepare for the future, similar to the findings of Warnock and colleagues (2010).

Many participants believe that being involved in the process of breaking bad news had some positive effects on patients/relatives and nurses. Approximately 61% felt that being involved in this process had strengthened their relationships with patients/relatives. This result was consistent with Warnock and colleagues (2010), who believe that nurses deal with many different cultures and ages, despite their lack of knowledge, while their attention to ethical principles when breaking bad news strengthens their relationships with patients/relatives. However, this finding is not in line with Alkhawaldeh et al. (2018), who documented that being involved in this process had strengthened participants' relationships with patients/relatives with the least frequency.

Furthermore, 68.1% of participants felt that being involved in this process had allowed them to share important life-changing moments with patients/relatives, similar to the findings of Warnock et al. (2010) and Mishelmovich et al. (2016). This could be explained by the nurses' focus on the moment of breaking bad news to patients, taking into

account the impact of time and ethical principles, because bad news changes their lives and this affects patients' treatment decisions, as they may not be ready for that bad news. All of these factors may be reflecting and changing the lives of patients and their families.

The findings of the current study revealed that Jordanian critical care nurses face many barriers when breaking bad news. The highest mean score for barriers was related to training, similar to the findings of Adebayo et al. (2013) and Alkhawaldeh et al. (2018); this might be due to lack of training and knowledge, unavailability of official curricula, and unavailability of standards or an effective protocol about breaking bad news. Based on the barriers faced by Jordanian nurses and the complexity of this task, adequate skills and knowledge are required to break bad news effectively. The same outcome was reported in physicians. In a study conducted by Arbabi et al. (2010), only 8% of the physicians were trained how to disclose bad news. In addition, Jedlicska et al. (2021) identified lack of education and training during medical school as a main barrier to delivering bad news effectively among physicians.

Regarding the work-related barriers, the lowest mean score was reported for feeling, which might be explained by the fact that nurses hide their sadness regarding the patient's health state and their anxiety for the patient's future and that they have the ability to withstand the emotions of patients (Alkhawaldeh et al. 2018). Previous research, however, suggests that this barrier is commonly reported among physicians. According to Farhat et al. (2015), many physicians avoid disclosing bad news to patients to avoid painful discussions and the negative responses of family members.

The highest item mean score among the top five barriers related to work-related preparation sub-scale was "knowing patients' medical histories". The high rate of this factor in the current study reflected the fact that the nurses are not prepared for this task, and perhaps due to parents' request to nurses not to tell the patient about his health condition or not to tell the patient except in the presence of the parents (Seresht and Izadi, 2013). This leads to difficulty in obtaining information related to medical history, which is difficult to obtain from a non-patient. Moreover, patients' negative reactions (anger, unawareness, and denial) may be a major barrier so that the nurse does not have sufficient medical information related to the patient's condition (Griffiths et al. 2015).

The lowest item mean score among the top five barriers during work-related communication and the information transfer sub-scale was "use clear language and avoid medical terms." This only constitutes a minor barrier to delivering bad news, perhaps because some nurses believe it necessary to use simple language with patients in a different culture as there are no specific policies related to the process of breaking bad news (Alkhawaldeh et al. 2018). They may also think that breaking bad news to younger patients is a barrier and that it is necessary to use simple language with patients, similar to Mishelmovich et al.'s (2016) result that disclosure of a terminal prognosis to younger patients is challenging.

The current study showed that attitudes, roles, and experiences of breaking bad news are significantly correlated. This outcome is expected and consistent with the previous research (Jeraine & Wakefield, 2018). Besides, most barriers of BBN were negatively associated with nurses' roles, attitudes, and experiences during BBN. This outcome suggests a need to overcome the barriers and obstacles they face when BBN.

Strengths and Limitations

The study was conducted in more than one unit (ED, ICU, and CCU) in the largest general governmental hospital in Amman-Jordan. The study participants were varied in cultural background, experience, and age, which help in generalizing the results of this study. However, the results of this study could not be considered without paying sufficient attention to its limitations. The first limitation was the self-reported questionnaire; participants' responses are influenced by the accuracy of their answers. Another limitation is that the results are not generalizable due to the use of a convenience sampling technique.

Implications for Practice

Hospital administrators and officials of critical care units have a responsibility to ensure that bad news is broken appropriately. The findings of the current study indicate a need to conduct educational programs to improve nurses' attitudes and roles in breaking bad news. There is also a need to clearly determine nurses' tasks in breaking bad news and to lay down formal legal responsibility for nurses regarding their obligations in breaking bad news to patients and their families. Hospital administrators may want to update nurses' knowledge related to breaking bad news; this would be reflected in their practice to overcome the barriers of breaking bad news in critical care units.

Conclusion

Nurses face many barriers to breaking bad news. Administrators should promote the involvement of nurses in breaking bad news and strengthen them through addressing these barriers, training, and education.

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