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Nurses' perspectives on breaking bad news to patients and their families: a qualitative content analysis

Abbas Abbaszadeh[1], Seyyedeh Roghayeh Ehsani[2], Jamal begjani[3], Mohammad Akbari Kaji[4], Fatemeh Nemati Dopolani[5], Amir Nejati[6], Esmaeil Mohammadnejad[7]

[1]Professor, Department of Nursing, Faculty of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran; [2]Department of Nursing, Imam Khomeini Hospital Complex, Tehran University of Medical Sciences, Tehran, Iran; [3]PhD candidate in Nursing, Department of Nursing Education , Islamic Azad University , Iranshahr Branch, Iranshahr , Iran; [4]PhD candidate in Nursing, Isfahan University of Medical Sciences, and Young Researchers Club, Islamic Azad University, Isfahan Branch (Khoorasgan),Isfahan, Iran; [5]Department of Nursing, Petruleum Hospital, Mahshar, Iran; [6]Assistant Professor, Department of Emergency Medicine, Imam Khomeini Hospital Complex, Tehran University of Medical Sciences, Tehran, Iran; [7]PhD candidate in Nursing, International Branch, Shahid Beheshti University of Medical Sciences, Tehran, Iran.

Corresponding Author:
Esmaeil Mohammadnejad
Address: First Floor , No. 9, Kavusi Alley, Urmia St, South Eskandari St, Tehran, Iran.
Email: asreno1358@yahoo.com
Tel: 98 21 66 93 66 26
Fax: 98 21 66 93 66 26

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Abstract

Breaking bad news is quite often not done in an effective manner in clinical settings due to the medical staff lacking the skills necessary for speaking to patients and their families. Bad news is faced with similar reactions on the part of the news receiver in all cultures and nations. The purpose of this study was to explore the perspectives of Iranian nurses on breaking bad news to patients and their families. In this research, a qualitative approach was adopted. In-depth and semi-structured interviews were conducted with 19 nurses who had at least one year work experience in the ward, and content analysis was performed to analyze the data.

Five major categories emerged from data analysis, including effective communication with patients and their families, preparing the ground for delivering bad news, minimizing the negativity associated with the disease, passing the duty to physicians, and helping patients and their families make logical treatment decisions.

The results of this study show that according to the participants, it is the physicians' duty to give bad news, but nurses play an important role in delivering bad news to patients and their companions and should therefore be trained in clinical and communicative skills to be able to give bad news in an appropriate and effective manner.

Keywords: ***nurses patients relationship, bad news, qualitative research***

Introduction

In modern medical ethics, one of the most important rights of patients is their will. Thus, physicians are obliged to present the necessary information to patients so they can make decisions about their disease and the diagnostic and therapeutic procedures. In recent decades, the physician-patient relationship has changed considerably. In most modern societies, paternalistic attitude is not acceptable in physicians and patients play a major role in making decisions about their health and therapeutic procedures (1, 2).

Patients' companions and relatives are sometimes exposed to news, events and conditions that they may consider as undesirable based on their notions of customs, common values, social habits and so on. Consequently, they evaluate the situation according to the above-mentioned criteria and show reactions that reflect their dissatisfaction with the circumstances (3-6).

Buckman was the first researcher to define bad news. According to him, anything that significantly and negatively affects the attitude of a person toward their future is called bad news (7). Philosophically, it can be claimed and then proved that "bad" and consequently "bad news" is something that people regard as evil. Recipients of bad news show similar reactions in all cultures and nations, and therefore it is possible to find common psychological and global elements to analyze such news (8). Breaking bad news is an emotional subject among health care professionals as patients' positive or negative experiences which can greatly affect their subsequent adaptation (9). Delivering bad news to patients and their companions is one of the most difficult aspects of the medical profession, and it is necessary for the therapeutic team to recognize the patients' social, psychological and clinical concerns (10). Telling patients that they are not emotionally prepared can have a negative effect on the course of treatment and communication with the therapeutic team. Some studies indicate, however, that giving information to patients does not necessarily cause anxiety, hopelessness, fear, depression and insomnia, and may even improve the patients' condition and their relationship with their relatives and the therapeutic team (11-13). Hiding information from patients prevents them from making proper therapeutic decisions based on their personal goals, as such decisions can increase costs, impose unnecessary distress, cause emotional and physical tension and lead to hopelessness and anxiety (14). When the therapeutic team can successfully recognize the patients' social, psychological and clinical concerns, it can identify and evaluate their absolute power and relative potential for handling the bad news and help establishing effective communication with patients and their families. Absolute power means social support and relative potential refers to stressors. By keeping a balance between these two, patients can be prepared to confront bad news (15). As important members of the therapeutic team, nurses can give necessary information to patients and their families and communicate to them facts about the disease. Based on ethical principles and the principle of beneficence in particular, patients should be fully informed about their conditions (16). Studies have shown that nurses are among the most valuable members of the therapeutic team and can play a key role in delivering bad news. Although nurses play an important part in communication between physicians, patients and their companions, their role in breaking bad news has been less emphasized. The present study was therefore conducted to investigate the subject of delivering bad news to patients and their families with a focus on the experiences of nurses in this regard.

Method

This qualitative study explored the experiences of nurses regarding breaking bad news to patients and their families. Nurses were selected from the Imam Khomeini Complex Hospital, a teaching hospital in Tehran, the capital city of Iran, affiliated with Tehran University of Medical Sciences (TUMS) during 2012 and 2013. Nurses were included if they were willing to participate and had at least one year experience in the ward.

In this study we used a content analysis approach. Qualitative content analysis can be described as a bridge between the original text and the presented results. It consists of a slow and systematic transformation of the original text into condensed categories and themes of meaning (17).

The participants were asked to describe one full day at work and then to explain their own experiences and perceptions about "breaking bad news to patients and their families". The main focus of the interview was the following question: 'What is your experience regarding breaking bad news to patients and their families?' The in-depth interviews lasted from 25 minutes to an hour, and some participants were interviewed twice by necessity. In this study, a total of 22 interviews were conducted with 19 nurses, who all had bachelor's (BS) or higher degrees in nursing. Inclusion criteria was having at least one year work experience in the ward.

Content analysis was conducted to analyze data. Data collection and data analysis were performed simultaneously. Qualitative research requires that the researcher be immersed in the data, so the researcher listened to the interviews and reviewed handwritten notes several times. The meaning units were extracted based on the participants' statements in the original codes. Then, based on the similarity of semantic and conceptual classifications, they were condensed and made as short as

possible. In the data reduction stage, the overall trend was to condense all analysis units, categories and subcategories. The data were then placed in the main categories which were more conceptual, and eventually the themes were extracted (17-19).

In order to ensure trustworthiness throughout our research, we used confirmability, credibility, dependability and transferability as advocated by Aein and Delaram, and Lincoln (20, 21). Credibility was established through prolonged engagement with the participants and applying their revisions using member checking procedure and peer debriefing. The findings and explanations of this study were reviewed by two supervisors with a sturdy background in qualitative research methodology. Moreover, maximum variation of sampling ensured conformability and credibility of the data. The study also provided sufficient descriptive data for researchers to determine whether the findings were transferable, which established applicability.

Permission to conduct this study was obtained from the ethics committee of the Imam Khomeini Complex Hospital. Other ethical issues in this study included the assurance of confidentiality and anonymity of the participants and their responses. All participants were informed about the objectives and methods of the study. They were also informed that participation in the study is voluntary, so they could refuse to participate or withdraw from the study at any time. Lastly, those who agreed to be included in the study were asked to sign a written consent.

Results

There were 19 nurses in this study, 11 females and 8 males, aged between 27 and 45, and most were employed as regular nurses. The mean age of the participants was 37.2 ± 4.1 years, and the mean of work experience was 13.2 years (Table 1).

Five themes emerged as a result of data analysis: effective communication with patients and their families, preparing the ground for delivering the bad news, minimizing the negativity associated with the disease, passing the duty to physicians, and helping patients and their families make logical treatment decisions (Table 2).

Table 1- Demographic profile of the participants

Sex
Male: 8 (42.1)
Female:11 (57.8)
Marital status
Married: 15 (78.9)
Single: 4 (21.05)
Educational level
BSc (bachelor's degree): 14 (73.6)
Higher than BSc: 5 (26.3)
Age
< 35: 6 (31.5)
36 - 40: 9 (47.3)
> 41: 4 (21.05)
Position
Nurse: 13 (68.4)
Head nurse: 4 (21.05)
Supervisor: 2 (10.5)
Years of work experience
< 5: 2 (10.5)
6 - 10: 6 (31.5)
11 - 15: 8 (42.1)
> 16: 3 (15.7)

Table 2- Main categories and subcategories

Main categories	*Subcategories*
Effective communication with patients and their families	Listening Feedback request Empathy and sympathy Respect for the other side
Preparing the ground for delivering the bad news	Offering an introduction to the bad news Considering patient morale Appropriate wording Assessment of the situation
Minimizing the negativity associated with the disease	Considering possible deterioration of the patient's clinical status Avoiding/postponing delivery of bad news
Passing the duty to physicians	Responsibility of the physician Adequate education Carelessness and irresponsibility by some nurses
Helping patients and their families make logical treatment decisions	Clarification of the nature of the disease Education on treatments, expenses, etc.

Effective communication with patients and their families

Nurses in this study emphasized the role of effective communication and believed that the exchange of information is essential in delivering bad news. Below are excerpts from the interviews:

"*… If you are going to tell a patient that she or he has a tumor, you should first prepare them for the news. The environment should be prepared and the patient's companions should not be present when you deliver the news* …" [nurse No. 9].

"*Nurses should not have to give bad news to patients or their families. They should listen to patients, sympathize with them and establish a sort of bilateral communication, but allow physicians to inform patients of the diagnosis and give them the news*" [nurse No. 17].

"We should direct the patients or their companions to a quiet and private place and then deliver the bad news. We should prepare them for hearing the news and pay attention to their feelings. If possible, we should cautiously give the news to the patient's companions" [nurse No. 11].

Preparing the ground for delivering the bad news

Research indicates that members of the therapeutic team and nurses in particular should be trained in delivering bad news, for instance news related to incurable diseases such as chronic illnesses, cancer, medical errors and death. Some participant comments in this regard were as follows:

"*There should be educational courses in hospitals to help us deliver bad news more efficiently. Sometimes patients' companions are agitated. They have right to be agitated. I don't know how to tell them that their patient died*" [nurse No. 15].

"*I don't know how to communicate bad news to patients' families. For some reason, I always try to leave it to my other colleagues. Each patient's situation is different, so there are different strategies for different people because characteristics of each patient are different. That's why there is a need for special skills*" [nurse No. 8].

On the other hand, one nurse believed that skills for communicating bad news can empower the therapeutic team. One nurse said, "*Training in bad news communication should be a clinical requirement. Unfortunately, most of us don't have the necessary knowledge and skills for breaking bad news, and those of us that do can't use them in clinical settings. It would be useful for us and other members of the therapeutic team to have more knowledge and training in that area*" [nurse No. 10].

Minimizing the negativity associated with the disease

Participants stated that sometimes they did not tell patients and their families the bad news in order to mitigate the seriousness of the situation. One participant said, "*I try not to tell patients the truth about their disease because their condition may be aggravated. I don't talk about the disease in the first session of chemotherapy. I just inform them about the nature of the disease and that they should receive medication. And if a patient has intensive hypertension, I tell them that their blood pressure is quite high and should be supervised by the physician*" [nurse No. 2].

Another nurse said, "*A patient who has brain tumor cannot undergo surgery due to metastasis. If they ask about their condition, I won't tell them that the tumor is metastatic, but rather that their condition may improve with medical treatment depending on the type of disease*" [nurse No. 13].

Passing the duty to physicians

Nurses in this study believed that physicians should tell their patients the bad news and it is not the nurses' responsibility to do so. Below are what some participants said in this respsct:

"*When patients ask me about their disease, I don't answer because I think it's the responsibility of the physician to answer such questions, and patients should ask those questions during doctor visits*" [nurse No. 6].

"*Telling patients about diagnosis and treatment increases the stress in the ward, both for me and my colleagues. I may not have full information, and when a patient asks me, I just say that I don't know and the physician will explain everything to them as soon as possible*" [nurse No. 10].

"*A patient comes in with abdominal pain and the physician's diagnosis is abdominal aneurysm. In this case, the physician should explain the patient's condition at the time of receiving informed consent …*" [nurse No. 1].

Helping patients and their families make logical treatment decisions

When nurses talk to patients who have cancer or incurable diseases, they can help them make informed decisions about continuation of treatment. Some nurses comments in this regard appear below:

"*If I tell the patients or their companions that the patient has a metastatic bladder tumor, they can make the proper decision about continuing treatment, and they may choose not to go to the hospital for pain relief. In such cases I will tell them to seek help at palliative care centers instead*" [nurse No. 4].

"*Sometimes patients think that their disease will be cured. They say that they will spare no expense and they don't care about the cost. They say that they will sell everything they have to cure their disease, but their disease is incurable …*" [nurse No. 9].

Discussion

One major problem that health care providers are facing is communicating diagnostic and

therapeutic clinical facts to patients and other members of the family (22-25). Patients and their companions may not be fully aware of the causes of the disease, the associated mortality rate or treatment options. On the other hand, patients have the right to be informed about their condition and the treatment process. Nurses believe, however, that it is not their responsibility to inform patients of diagnostic facts, and therefore try to leave the task to the physician. In this way they will avoid the reactions of patients and their companions after receiving the bad news and possible legal consequences (26). Breaking bad news has always been regarded as one of the duties of the physician, which is in line with the findings of the present study. Telling bad news has also been mentioned as an issue which can involve all members of the medical community (27).

In the present study, one category that emerged as a result of data analysis was effective communication with patients and their families. Communication refers to a transaction and a process of creating messages that occurs in a setting comprising the physical environment, cultural and social standards and psychological situations (28). Communicative skills are at the heart of clinical abilities and play an effective role in the promotion of health, therapeutic procedures and patient satisfaction (29).

Studies have also shown that medical teams have trouble delivering bad news. The main reason for physicians' reluctance to give bad news may be lack of skills (20, 30). Effective communication is the basis of trust and mutual understanding and weak communication prevents tasks from being performed properly, which in turn reduces efficiency and increases misunderstanding (31). The relationship between therapeutic teams and patients is at the center of all clinical actions, and may well be the cornerstone of medical activity (32). Effective communication plays an important role in health care and is a mixture of communication, education, anthropology, behavioral skills and a number of basic sciences (33). The nurse-patient communication begins with the initial encounter between the two and lasts for the duration of the therapeutic relationship. The nurses' objective would be to create and maintain a suitable professional relationship with patients, and they should therefore try to win their patients' trust from the start. This is possible only if communication takes place in proper settings and is accompanied by compassion and respect on the part of the nurse (28).

There are different protocols and instructions with regard to giving information to patients. Kirshblum and Fichtenbaum proposed a three-step protocol for breaking the news, including preparation, dialogue and conclusion (34). Disclosure of facts, particularly bad news, should be done in a step by step manner, and like all therapeutic procedures, success of each stage depends on the desirable completion of the previous stage. The SPIKES clinical protocol can be applied when delivering bad news to patients. The protocol includes providing the proper setting for breaking the news, checking the patient's perception of the condition, obtaining the patient's invitation, presenting the knowledge and information, recognition of the patient's emotions through empathic responses, and strategy and summary (35). A similar model has been proposed by Rabow and McPhee which includes the following stages: preparation, creation of an environment suitable for therapeutic communication, effective communication, dealing with reactions of patients and their families, and encouragement and validation of patients' emotions (36). Another strategy for announcing news is the PEWTER model. This model includes six main steps of preparation, evaluation, warning, telling, emotional response, and regrouping. These instruments can be used by emergency service providers who are responsible for delivering news such as deaths, crimes and unexpected events while providing emergency services (37).

One finding of the present study was that the medical team may give inaccurate information to patients. The amount and content of information they communicate to each patient may vary according to the patient's condition. Based on our findings, factors such as complexity of treatment, hazards of medical and surgical interventions and personal demands of patients can affect this issue. There is evidence that medical teams prefer to minimize the negative aspects of the disease so that patients do not lose hope and their symptoms are not aggravated (27). The amount of the information that is presented to patients is based on their level of understanding and needs. Too much information can increase confusion, fear and anxiety in patients (13). Skillful, tactful, prudent and comprehensive announcement of bad news to patients and their families will comfort them and provide control over the present and future consequences of the news (38, 39).

One benefit of delivering bad news to patients is that they can make logical decisions to continue treatment. From the Islamic viewpoint, people have the right to know the facts that directly concern them so they can make plans about their future. Holy Quran states that valuable actions are performed based on divine values, freely and consciously. In fact, Islam declares that if a person is competent, they should be allowed to make decisions. On the other hand, Islam places special emphasis on making preparations before one's death. A person's final days can be a suitable opportunity for believers to compensate loss, return trusts and settle displeasures (1, 15). On the other

hand, withholding facts about the disease causes problems such as failure to make proper therapeutic decisions based on personal goals, increased costs, unnecessary stress and distress (11, 12). Hence, bad news must be communicated to patients and their families so they can make logical and proper decisions.

Conclusion

Giving bad news to patients is one of the most difficult tasks that members of the therapeutic team have to perform. Breaking bad news is the duty of the physicians, but nurses may play an important role in delivering news to patients and their companions, and should therefore be trained in the clinical and communication skills that are necessary for doing so. It should also be noted that the strategies for breaking bad news vary across different cultures and nations.

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