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Knowledge, Views And Experience Of Breaking Bad News Among Primary Health Care Physicians In Taif

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ABSTRACT

Background: *Breaking bad news is an essential skill of any family physician and general practitioner (GP). Our training and values support open and honest communication between the physician and patient. As a result, family physicians and GPs are in an ideal position to help patients with a terminal disease face their illness with compassion and dignity.*

Objectives: *To assess knowledge, views and experience of breaking bad news as well as the relationship between the socio-demographic variables, job characteristics and knowledge regarding breaking bad news among family physicians and general practitioners.*

Methodology: *This study is a descriptive cross- sectional study. It included all family physicians and general practitioners working in primary health care centers during the study period in Taif, Saudi Arabia. A self-administered questionnaire based on the main steps of breaking bad news especially SPIKES mode was utilized for data collection. It consisted of two parts: the first part includes the personal characteristics (gender, age, nationality, marital status, title, qualifications and years of practice) while the second part contains questions, based on the main steps of breaking bad news especially SPIKES model, to assess their knowledge, views and experience of breaking bad news.*

Results: *The study included 121 primary health care physicians with a response rate of 80.7%. Males represent 59.5% of them. Their age ranged between 22 and 60 years with a mean of 36.7 years and standard deviation of 9.5 years. More than half of them (54.5%) were non-Saudis. Almost one third of the PHC physicians (34.7%) attended training courses on breaking bad news mostly lectures [1](62%). Overall, Sufficient knowledge regarding breaking bas news was reported among 12.4% of PHC physicians. Older (>45 years old), non-Saudi, more experienced, higher educated, consultant physicians and those attended training courses in breaking bad news were more significantly knowledgeable. Majority of the physicians agreed that patients should be informed about a serious life threatening illness (80.9%) and guidelines or protocols as helpful with respect to breaking bad news (91.8%). However, 58.6% of them agreed that Saudi patients would prefer to be told about a serious illness.*

Conclusion*: Although the primary physicians are keen to help their patients, most of them lack the essential knowledge and skills of breaking bad news. However, their views towards breaking bad news are encouraging in general.*

INTRODUCTION

[1]Family Medicine Consultant, Southern Aljanoubiah Primary Health Care in Taif.
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1) Background:

Bad news is "any news that drastically and negatively alters the patient's view of her or his future." [1]

Bad news is stereotypically associated with a terminal diagnosis, but family physicians encounter many situations that involve imparting bad news; for example, a pregnant woman's ultrasound verifies a fetal demise, a middle-aged woman's magnetic resonance imaging scan confirms the clinical suspicion of multiple sclerosis, or an adolescent's polydipsia and weight loss prove to be the onset of diabetes.

There are many reasons why physicians have difficulty breaking bad news. A common concern is how the news will affect the patient, and this is often used to justify withholding bad news. Physicians also have their own issues about breaking bad news. It is an unpleasant task. Physicians do not wish to take hope away from the patient. They may be fearful of the patient's or family's reaction to the news, or uncertain how to deal with an intense emotional response. Historically, the emphasis on the biomedical model in medical training places more value on technical proficiency than on communication skills. Therefore, physicians may feel unprepared for the intensity of breaking bad news, or they may unjustifiably feel that they have failed the patient. The cumulative effect of these factors is physician uncertainty and discomfort, and a resultant tendency to disengage from situations in which they are called on to break bad news. [2]

In the past few decades, traditional paternalistic models of patient care have given way to an emphasis on patient autonomy and empowerment. A review of studies on patient preferences regarding disclosure of a terminal diagnosis found that 50 to 90 percent of patients desired full disclosure. [3] Because a sizable minority of patients still may not want full disclosure, the physician needs to ascertain how the patient would like to have bad news addressed. Qualitative studies about the information needs of cancer patients identify several consistent themes, but which theme is most important to any given patient is highly variable and few patient characteristics accurately predict which theme will be most important.[4] Therefore, the physician faces the challenge of individualizing the manner of breaking bad news and the content delivered, according to the patient's desires or needs.

Several professional groups have published consensus guidelines on how to discuss bad news; however, few of those guidelines are evidence-based.[5] The clinical efficacy of many standard recommendations has not been empirically demonstrated.[6,7] Less than 25 percent of publications on breaking bad news are based on studies reporting original data, and those studies commonly have methodologic limitations.

SPIKES Model:

S : Setting up the interview

P : Assessing the patient's **P**erception

I : Obtaining the patient's **I**nvitation

K : Giving **K**nowledge and information to the patient

E : Addressing the patient's **E**motions with empathic response

S : Strategy and **S**ummery

2) Aim of the study:

To assess quality of breaking bad news among family physicians and general practitioners

3) Objectives:

1) To assess knowledge, views and experience of breaking bad news among family physicians and general practitioners.
2) To assess relationship between the socio-demographic variables, job characteristics and knowledge regarding breaking bad news.
3) To explore reasons of difficulty in breaking bad news.

4) Rationale:

1) In medical practice, we encounter many clinical situations needing breaking bad news.

2) The emphasis on the biomedical model in medical training places more value on technical proficiency than on communication skills.

3) There is poor knowledge on communication skills compared to biomedical skills.

4) The researcher's speciality as a family physician focuses on communication skills including breaking bad news skills.

LITERATURE REVIEW

1- Studies in KSA:

1. A study done in Al-Qassim, 2013, revealed that the majority (70%) of physicians preferred to discuss information with close relatives rather than the patients. In case of serious diseases, only 32% said that they would inform the patient's family without the patient's consent. More than 90% of their study sample did not avoid telling their patients the bad news; however, physicians working in Primary Healthcare centers were less reserved. It concludes that most of the participating physicians were keen to help their patients, but they lacked the essential knowledge and skills for breaking bad news. Thus, they are in need of specific training in this regard.[8]

2- International Studies:

1- A study published in Canada,

2- that the majority of consultants in clinical specialties 2001, concluded that most medical and surgical residents realize important guidelines in the delivery of bad news, their own fears, a general lack of supervisory support and time constraints form barriers to their effective interaction with patients.[9]

3- A study published in UK, 2007, explored reported breaking bad news frequently (> 1-2 times weekly); however, almost half (49%) had received no formal training in this specific area, although 53% described having received experiential training in either clinical, training or management contexts.[10]

4- A study published in UK,2011, explored that Consultants from different specialties mainly focused upon providing biomedical information and did not discuss lifestyle and psychosocial issues frequently.[11]

5- A study published in Germany among Chinese oncologists, 2012, revealed that the participants stated that in most cases (78%), they inform family members first.

Contrary to this practice, participants think that about 75% of patients would like to be informed first, independent of family.[12]

6- A study published in Italy among Italian oncologists in 2013, revealed that Physicians' age and sex influence breaking bad news to elderly cancer patients.[13]

7- A study published in Australia, 2013, provides insight into the range of different coping responses and stress experienced by doctors in relation to the task of breaking bad medical news.[14]

8- A study done in Poland,2013, revealed that a total of 28 % medical students and 24 % physicians ($p = 0.282$) were ready to reveal full information to advanced cancer patients, and concludes that breaking bad news is a significant difficulty for both medical students and physicians.[15]

9- A study published in Pakistan among Pakistani radiologists, 2013, concludes that for severe abnormalities such as malignancy, 50% residents, 55% of the academic radiologists and 74% of the private practicing radiologists were very uncomfortable in disclosure of results. Differences in frequency of communication with patients were noticed with both different training levels, and different settings of practice in a developing country.[16]

METHODOLOGY

1- **Study Area:**

Taif City:

Taif is a city in the Mecca Province of Saudi Arabia at an elevation of 1,879 m (6,165 ft) on the slopes of the Sarawat Mountains (Al-Sarawat Mountains). It has a population of 1.011.613. Each summer the Saudi Government moves from the heat of Riyadh to Ta'if. The city is the centre of an agricultural area known for its grapes, pomegranate, figs, roses and honey. Taif has a mild desert climate with hot summers and mild winters. Temperatures are not as extreme in summer as for lower-lying regions of Saudi Arabia. Precipitation is low, but all months see some rain, with more rain in spring and late autumn than in other months[17].

Primary Health Care in Taif:

In Taif City there are 17 governmental (MOH) primary health care centers, Prince Mansour Military Hospital for Community and Family Medicine and National Guard PHC Center.

2- **Study design:**

-This study is a descriptive cross- sectional study.

3- **Study population:**

All family physicians and general practitioners working in primary health care centers during the study period in Taif, Saudi Arabia.

4- **Sample size**

The total number of family physicians and general practitioners working in PHC Centers in Taif is 150 physicians.

5- **Sampling technique:**

Owing to the small number of the physicians, all physicians present at the time of study were invited to participate in the study.

6- **Population selection criteria:**

Inclusion criteria:

1) Family physician and GPs working in PHC Centers in Taif city, Saudi Arabia.
2) Both male and female gender.
3) All nationalities.
4) All ages.

Exclusion criteria:

1) All other specialized physicians in PHC Centers like (pediatricians, obstetric & gynecologists, dentists and interns).
2) Family physicians & GPs who are not present at the time of conducting the study and not present in the area of the study.

7- **Data Collection:**

Data collection tool:
A self-administered questionnaire based on the main steps of breaking bad news especially SPIKES model.

The questionnaire consists of two parts:

The first part:
Includes the personal characteristics (gender, age, nationality, marital status, title, qualifications and years of practice)

The second part:

Based on the main steps of breaking bad news especially SPIKES model to assess their knowledge, views and experience of breaking bad news.

Data collection technique:

1) The researcher visited the selected primary health care centers after getting approval, the researcher got permission from primary health care directors and physicians. The researcher explained the purpose of the study to all family physicians and GPs.
2) The main tool of the study was a self-administered questionnaire with a cover letter explaining the purpose of the study without mention of names to ensure confidentiality.
3) The questionnaire was distributed to Family physicians & GPs by the researcher himself hand to hand during their break or free time according to each physician in his or her clinic, and then collected in the same way either immediately or after a

period of time with follow up through phone or e-mail to those who did not respond immediately.

8- **Data Entry and Analysis:**

1) All collected data were verified by hand and corrected whenever necessary then coded before its entry to a personal computer.

2) Data entry and analysis was done by using the Statistical Package of the Social Sciences (SPSS)® statistical program, version 20.

3) Chi-square test was applied to test for the association and/or difference between categorical variables. Fisher`s Exact test was used instead, in case of small frequencies.

4) P-value of equal or less than 0.05 was considered as a level for significance throughout the study.

9- **Pilot Study:**

1) Pilot study was conducted on 15 physicians (family physicians & GPs) representing 10% of the total sample size to test the questionnaire applicability and understanding before starting the actual research. As a feedback, the questionnaire was clear and understandable.

2) The data from pilot study were analyzed and included in the main study since there was no difference from the main survey.

3) Time was assessed for each participant to complete one questionnaire. An average of 12 minutes was needed to complete the questionnaire by physicians.

4) Methodology was tested and no modifications were made accordingly.

10- **Ethical considerations:**

1) Approval of Joint Program of Family & Community Medicine – Taif was obtained.
2) Permission of all primary health care centers directors and physicians was obtained.
3) All collected data were kept confidential.
4) Ethical consideration was taken through all the researcher steps.

11- **Budget:**

Self- funded.

12- **Manpower:**

The researcher was the only one responsible for distributing and collecting the questionnaires**.**

RESULTS

Response rate: Out of 150 physicians targeted for study inclusion, 121 actually participated giving a response rate of 80.7%.

Personal characteristics: The study included 121 primary health care physicians. Table 1 presents their personal characteristics. Males represent 59.5% of them. Their age ranged between 22 and 60 years with a mean of 36.7 years and standard deviation of 9.5 years. Forty-three percent of them aged between 31 and 45 years. More than half of them (54.5%) were non-Saudis. Most of them (78.5%) were married. More than half of them (52.1%) were general practitioners whereas 29.7% were family medicine residents and 6.6% were consultants. Majority of them (84.3%) were MBBS holders whereas 11.6% were Board or equivalent holders. Their experience ranged between one and 30 years with a mean of 7.8 years and standard deviation of 7.3 years. More than half of them (52.1%) had experience of 5 years or less.

Table 1: Personal characteristics of the participants (n=121)

	Frequency	**Percentage**
Gender		
Male	**72**	**59.5**
Female	**49**	**40.5**
Age		
≤30	**45**	**37.2**
31-45	**52**	**43.0**
>45	**24**	**19.8**
Range	**22-60**	
mean±SD	**36.7±9.5**	
Nationality		
Saudi	**55**	**45.5**
Non-Saudi	**66**	**54.5**
Marital status		
Single	**26**	**21.5**
Married	**95**	**78.5**
Title		
Consultant	**8**	**6.6**
Senior registrar	**7**	**5.8**
Registrar	**7**	**5.8**
Family medicine resident	**36**	**29.7**
General practitioner	**63**	**52.1**
Qualification		
MBBS	**102**	**84.3**
Diploma	**5**	**4.1**
Board/equivalent	**14**	**11.6**
Experience (years)		
≤5	**63**	**52.1**
6-10	**25**	**20.6**
>10	**33**	**27.3**
Range	**1-30**	
mean±SD	**7.8±7.3**	

Attendance of training courses on breaking bad news: Almost one third of the PHC physicians (34.7%) attended training courses on breaking bad news as illustrated in Figure 1. These training courses were mostly lectures (62%), followed by workshops (26.6%) and symposium (11.4%). Figure 2

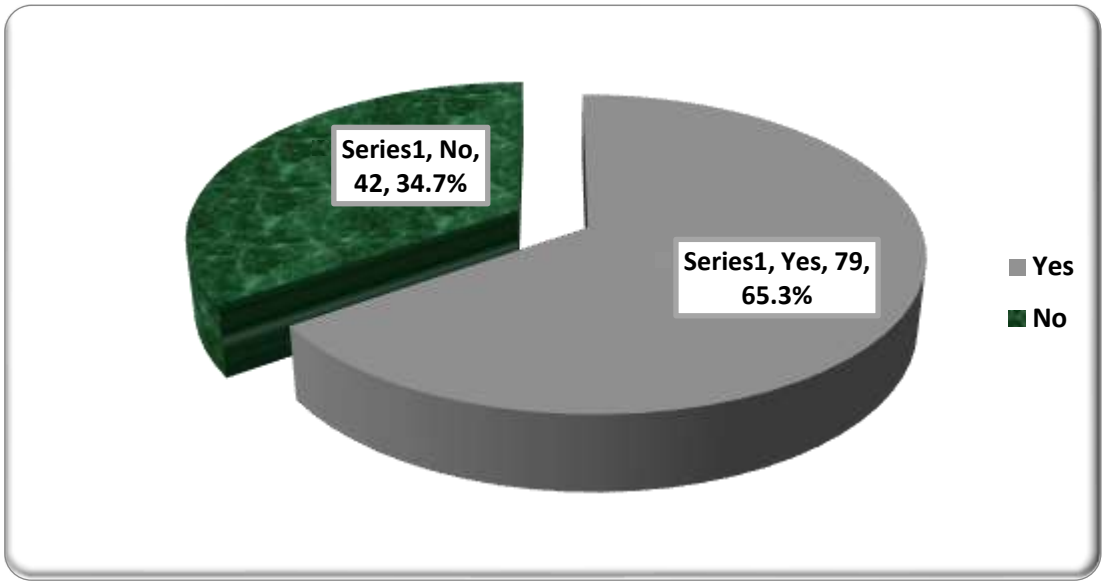

Figure 1: History of attending any training course on breaking bad news.

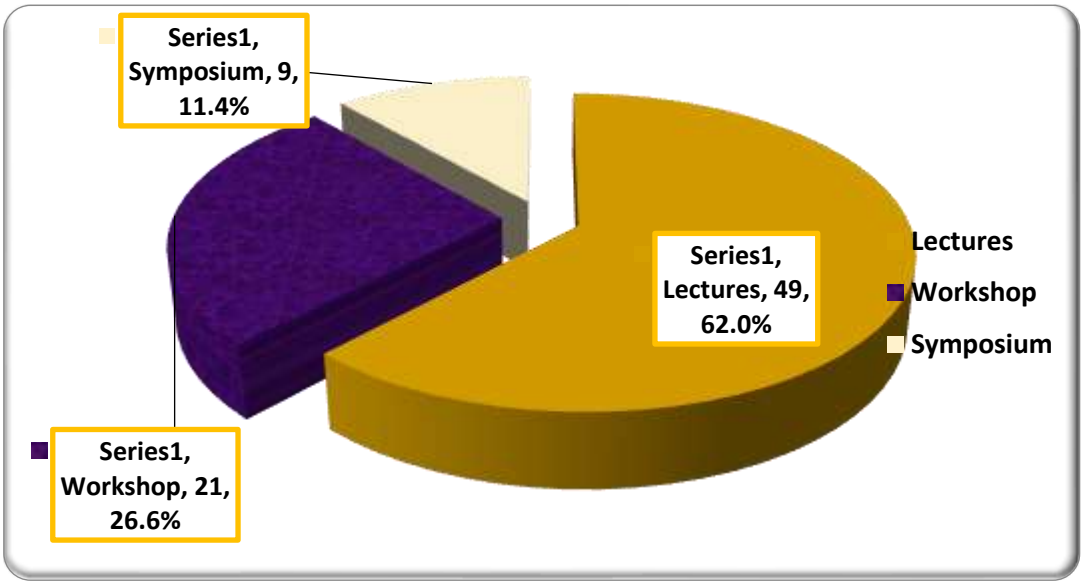

Figure 2: Type of training courses on breaking bad news (n=79).

Physicians` knowledge of breaking bad news

As demonstrated in table 2, the majority of the physicians (96.7%) recognized correctly that informing patients about bad news requires specific precautions and most of them recognized that informing patients regarding bad news can't be done at any place in the hospital as well at any time (86%) and it is not more successful to give false hope to terminal patients (76.9%). Almost two-thirds of them knew correctly that Saudi patients want to know about the disease and its prognosis (63.6%) and informing patients regarding bad news should include fine details about their health status with particular emphasis on the prognosis (60.3%). Only 15 physicians (12.4%) knew correctly SPIKES protocol or model

for delivering bad news. Fifty five physicians knew that patients should be given bad news first.

Overall, Sufficient knowledge regarding breaking bas news was reported among 12.4% of PHC physicians. Figure 3

Table 2: Physicians` knowledge of breaking bad news

Questions	Right answers	
	Number	Percentage
Is it always right to inform the patient about an incurable disease and unfavorable prognosis? (YES)	44	36.4
Who should be given bad news first? (the patient)	55	45.5
How bad news should be given? (It depends on patient's desire)	58	47.9
Do you know SPIKES protocol or model for delivering bad news? (YES)	15	12.4
S (Setting up the interview)	15	12.4
P (Assessing the patient's Perception)	15	12.4
I (Obtaining the patient's Invitation)	15	12.4
K (Giving Knowledge and information to the patient)	15	12.4
E (Addressing the patient's Emotions with empathic response)	15	12.4
S (Strategy and Summery)	15	12.4
Do you know another protocol or model for delivering bad news? (YES)*	16	13.2
Informing patients regarding bad news can be done at any place in the hospital as well at any time (No)	104	86.0
Informing patients regarding bad news does not require specific precautions (No)	117	96.7
Informing patients regarding bad news should include fine details about his health status with particular emphasis on the prognosis (YES)	73	60.3
Saudi patients do not want to know about the disease and its prognosis (No)	77	63.6
It is more successful to give false hope to terminal patients (No)	93	76.9

*ABCDE protocol (14) and BMJ (1) and AAFP (1)

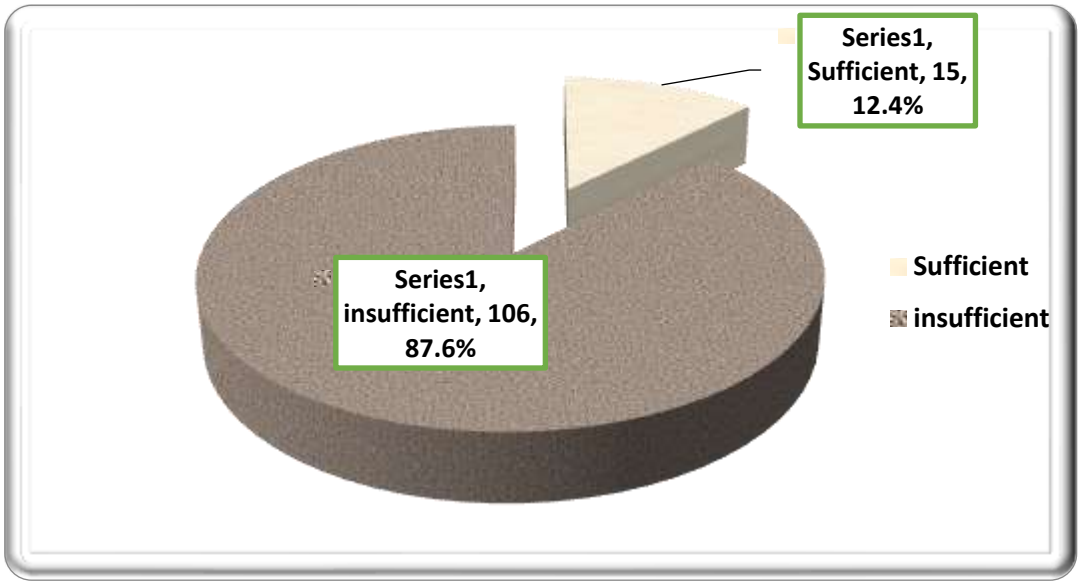

Figure 3: Overall knowledge regarding breaking bad news among PHC physicians, Taif

Factors associated with knowledge of breaking bad news:

-Socio-demographic factors

From table 3, one third of older physicians (>45 years) compared to only 2.2% of those aged ≤30 years had sufficient breaking bad news knowledge. This difference was statistically significant, p=0.0.001. Almost one-fifth of non-Saudi physicians (18.2%) compared to 5.5% of Saudi physicians had sufficient breaking bad news knowledge. The difference was statistically significant, p=0.030. Half of the consultants compared to 5.6% of family medicine residents and 9.5% of general practitioners had sufficient breaking bad news knowledge. The difference was statistically significant, p=0.007. More than one third of physicians who had Diploma (40%) or Board/equivalent (35.7%) compared to only 7.8% of those who had MBBS degree had sufficient breaking bad news knowledge. The difference was statistically significant, p=0.002. Regarding experience, 30.3% of physicians who had more than 10 years of experience compared to 3.2% of those who had an experience of 5 years or less had sufficient breaking bad news knowledge. The difference was statistically significant, p=0.002. There was no significant difference between male and female physicians regarding breaking bad news knowledge.

Table 3: Association between socio-demographic characteristics of physicians and knowledge of breaking bad news

	Breaking bad news knowledge		χ^2 (p-value)
	Insufficient N=106	**Sufficient N=15**	
Gender			
Male (n=72)	64 (88.9)	8 (11.1)	**0.27**
Female (n=49)	42 (85.7)	7 (14.3)	**(0.603)**
Age (years)			
≤30 (n=45)	44 (97.8)	1 (2.2)	
31-45 (n=52)	46 (88.5)	6 (11.5)	**14.01**

>45 (n=24)	16 (66.7)	8 (33.3)	**(0.001)**
Nationality			
Saudi (n=55)	52 (94.5)	3 (5.5)	
Non-Saudi (n=66)	54 (81.8)	12 (18.2)	**0.030***
Title			
Consultant (n=8)	4 (50.0)	4 (50.0)	
Senior registrar (n=7)	6 (85.7)	1 (14.3)	
Registrar (n=7)	5 (71.4)	2 (28.6)	
Family medicine resident (n=36)	34 (94.4)	2 (5.6)	**14.16**
General practitioner (n=63)	57 (90.5)	6 (9.5)	**(0.007)**
Qualification			
MBBS (n=102)	94 (92.2)	8 (7.8)	
Diploma (n=5)	3 (60.0)	2 (40.0)	**12.47**
Board/equivalent (n=14)	9 (64.3)	5 (35.7)	**(0.002)**
Experience (years)			
≤5 (n=63)	61 (96.8)	2 (3.2)	
6-10 (n=25)	22 (88.0)	3 (12.0)	**14.68**
>10 (n=33)	23 (69.7)	10 (30.3)	**(0.001)**

*** Fischer exact test**

Table 4 shows that 16.2% of physicians who attended courses about breaking bad news compared to 4.8% of those who did not attend such courses had sufficient breaking bad news knowledge. This difference was borderline significant, p=0.053. However, the type of training course was not significantly associated with breaking bad news knowledge.

Table 4: Association between physicians` attendance of training courses and knowledge of breaking bad news

	Breaking bad news knowledge		χ^2 (p-value)
	Insufficient N=106	**Sufficient N=15**	
Attending any training course on breaking bad news.			
Yes (n=79)	66 (83.5)	13 (16.2)	
No (n=42)	40 (95.2)	2 (4.8)	**0.053***
Type of training courses on breaking bad news	**N=66**	**N=13**	
Lecture (n=49)	39 (79.6)	10 (20.4)	
Workshop (n=21)	19 (90.5)	2 (9.5)	**1.48**
Symposium (n=9)	8 (88.9)	1 (11.1)	**(0.478)**

*** Fisher`s Exact test**

Experience in breaking bad news

From figure 4, it is clear that 41.3% of the physicians have been involved in initiation of breaking bad news. Table 5 shows that there was no statistically significant association between involvement of physicians in breaking bad news and their knowledge about it. Almost two thirds of physicians (62%) described themselves as fairly confident while breaking bad news whereas 34% were not sure of confidence and only 4% were confident while breaking bad news. Figure 5

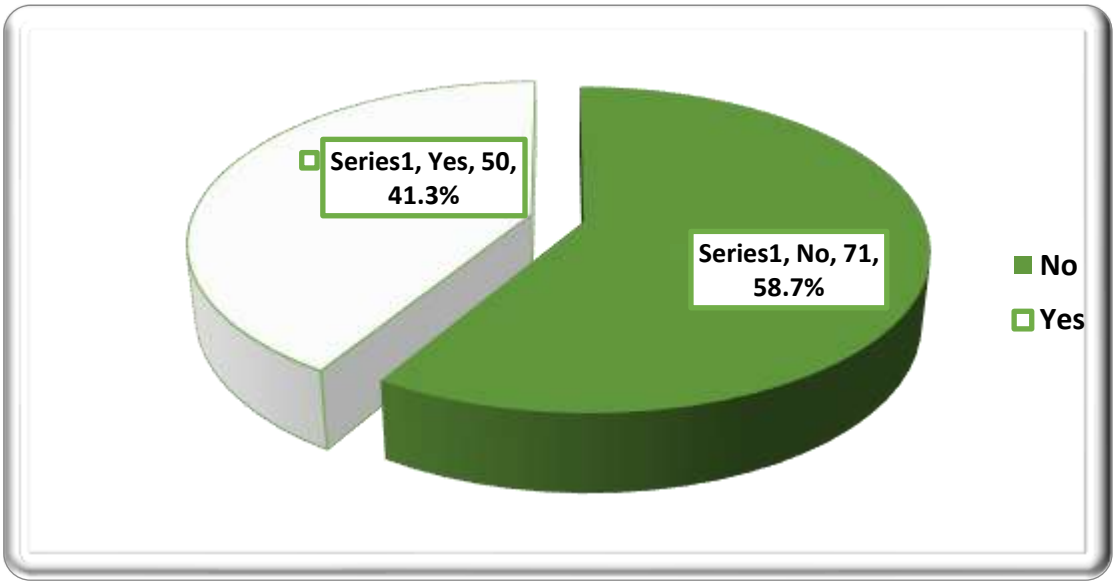

Figure 4: History of involving in breaking bad news among primary health care physicians.

Table 5: Association between physicians` history of involvement in breaking bad news and knowledge of breaking bad news

Involved in breaking bad news	Breaking bad news knowledge		χ^2 (p-value)
	Insufficient N=106	Sufficient N=15	
Yes (n=50)	47 (94.0)	3 (6.0)	
No (n=71)	59 (83.1)	12 (16.9)	**0.062***

*** Fisher`s Exact test**

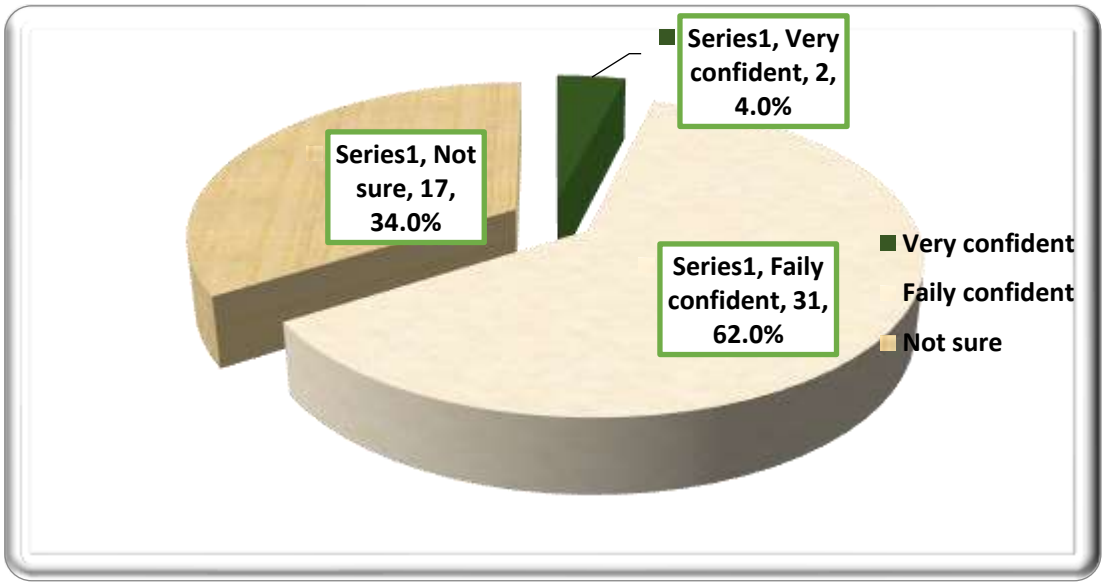

Figure 5: Physicians` self description while breaking bad news.

Difficulties when talking about bad news

From table 6, it is shown that the most commonly reported difficulties faced by physicians when talking about breaking bad news, either often or sometimes were dealing with emotions of the patient/relatives (95%), having all the relevant information available about disease and its prognosis (92.6%), use of non-medical terminology (91.7%), dealing with their own emotions (90%) and judging how much information people want (89.3%). The least reported difficulties were being honest to patients/relatives and thinking that they were not the appropriate persons to discuss the bad news (65.3%).

Table 6: History of having difficulties when talking about bad news among PHC physicians.

	Often **N (%)**	**Sometimes** **N (%)**	**Never** **N (%)**
Having all the relevant information available about disease and its prognosis	**17 (14.0)**	**95 (78.6)**	**9 (7.4)**
Use of non-medical terminology	**13 (10.7)**	**98 (81.0)**	**10 (8.3)**
Allowing for pauses	**16 (13.2)**	**89 (73.6)**	**16 (13.2)**
Dealing with emotions of the patient/relatives	**44 (36.4)**	**71 (58.6)**	**6 (5.0)**
Dealing with my own emotions	**28 (23.1)**	**81 (66.9)**	**12 (10.0)**
Handling uncertainty	**14 (11.6)**	**92 (76.0)**	**15 (12.4)**
Being honest to patients/relatives	**26 (21.5)**	**53 (43.8)**	**42 (34.7)**
Thinking that I was not the appropriate person to discuss the bad news	**8 (6.6)**	**71 (58.7)**	**42 (34.7)**
Lack of privacy	**26 (21.5)**	**62 (51.2)**	**33 (27.3)**
Judging how much information people want	**21 (17.4)**	**87 (71.9)**	**13 (10.7)**
Patients/relatives who do not speak or understand my language	**20 (16.5)**	**82 (67.8)**	**19 (15.7)**

Physicians` opinion towards ethical aspects of breaking bad news

Most of the physicians either strongly agreed or agreed that guidelines or protocols as helpful with respect to breaking bad news (91.8%) patients should be informed about a

serious life threatening illness (80.9%). More than half of them either strongly agreed or agreed that Saudi patients would prefer to be told about a serious illness (58.6%) and doctors need to judge whether or not to tell a patient bad news (53.7%). Table 7

Table 7: Physicians` view that reflects your opinion towards ethical aspects of breaking bad news.

Ethical aspects	Strongly agree N (%)	Agree N (%)	Not sure N (%)	Disagree N (%)	Strongly Disagree N (%)
Patients should be informed about a serious life threatening illness	41 (33.9)	56 (46.3)	16 (13.2)	8 (6.6)	0 (0.0)
Doctors need to judge whether or not to tell a patient bad news.	11 (9.1)	54 (44.6)	9 (7.4)	35 (28.9)	12 (9.9)
Doctors should follow the wish of relatives not to inform a competent patient about bad news.	9 (7.4)	36 (29.8)	17 (14.0)	42 (34.7)	17 (14.0)
Guidelines or protocols as helpful with respect to breaking bad news.	37 (30.6)	74 (61.2)	8 (6.6)	2 (1.7)	0 (0.0)
Saudi patients would prefer to be told about a serious illness	9 (7.4)	62 (51.2)	42 (34.7)	7 (5.8)	1 (0.8)

Physicians` opinion towards different aspects of breaking bad news From table 8, it is shown that majority of the physicians agreed that before the patient leaves the office they should make sure to give him/her a follow-up plan and provide him/her with some hope. Most of them agreed that before telling the bad news fire a ≪warning shot≫ that some bad news is coming (87.6%) and if they were suffering from a terminal disease, they would like to be fully informed about it. Almost two-thirds of them (61.1%) felt depressed after breaking bad news to the patient/relatives. Only 15.7% of them agreed that a multi-bed hospital room can be used to deliver the news.

Table 8: Physicians` opinion towards different aspects of breaking bad news

Statements	Agree N (%)	Neutral N (%)	Disagree N (%)
I usually avoid telling my patients about their final diagnosis.	7 (5.8)	12 (9.9)	102 (84.3)
The patient always has the right to know his/her diagnosis.	98 (81.0)	21 (17.3)	2 (1.7)
A multi-bed hospital room can be used to deliver the news.	19 (15.7)	10 (8.3)	92 (76.0)
Before telling the bad news fire a ≪warning shot≫ that some bad news is coming.	106 (87.6)	8 (6.6)	7 (5.8)
Before the patient leaves the office make sure to give him/her a follow-up plan and provide him/her with some hope.	114 (94.2)	7 (5.8)	0 (0.0)
If I was suffering from a terminal disease I would like to be fully informed about it	105 (86.8)	12 (9.9)	4 (3.3)
I feel depressed after breaking bad news to the patient/relatives	74 (61.1)	40 (33.1)	7 (5.8)

DISCUSSION

There is now ample evidence that patients cope better with serious illnesses if they are kept informed.[8] The majority of the studies implemented to explore physicians knowledge and views with regard to the communication of bad news used descriptive evidence or qualitative measures. The majority was conducted in Western countries [18] and used different measures to obtain information. To our knowledge, this is the only study conducted in Taif, Saudi Arabia with the objective of exploring the physicians` knowledge and views as well as difficulties of breaking bad news.

In the present study, most of family physicians and general practitioners had insufficient knowledge regarding breaking bad news. This finding obviously will affect the effectiveness of delivering bad news to patients. The first and perhaps the most important barrier is doctors' lack of training in communication skills. Epstein found that most clinicians have had little formal training in communication skills. [19] Fortunately, almost two-thirds of our physicians attended training courses in BBN. This finding raises the question about the quality of such training courses.

Physicians tend to rely on their intuition and experience, and contrary to the research evidence which shows that communication skills do not reliably improve with experience; [20] there is an assumption that communication skills will be acquired with time. Fallowfield stated that too many of their doctors are forced to rely on intuition to guide them as to what to say or how to say things to patients. [21] In accordance with this finding, our study revealed that more experienced, higher educated and consultant physicians had better knowledge of BBN. Non-Saudi physicians were more knowledgeable and this could be attributed to the fact that they were older and more experienced than Saudi physicians.

Lack of training leads to substandard skills. Physicians should be trained to recognize, first of all, that it is their responsibility to get the process of breaking bad news right. They should also be prepared to invest time when delivering the news to minimize problems later. As professionals, they must take responsibility for the development and improvement of their own communication skills. The General Medical Council and other medical professional bodies have stressed the importance of doctors developing good communication skills. [22]

Physicians have to respond to the differing needs of a hugely diverse range of patients and relatives. Patients and relatives have different backgrounds, cultures, religions, languages, levels of intelligence, and ages. These variations put demands on doctors to adjust the manner of delivering bad news accordingly, which may influence the doctors' ability to effectively deliver the bad news. [23] In the present study, the commonest reported difficulties by physicians in delivering BBN were dealing with emotions of the patient/relatives (95%), having all the relevant information available about disease and its prognosis (92.6%), use of non-medical terminology (91.7%), dealing with their own emotions (90%) and judging how much information people want (89.3%).

Empathic communication is the key. This is particularly true in breaking bad news encounters. We found the work of Baile and colleagues [24] who organized recommendations into the mnemonic SPIKES: Setting up, Perception, Invitation, Knowledge, Emotions, Strategy and summary rather simple and a useful approach. This approach is intended to help clinicians break bad news to patients in a straightforward and empathic manner. Unfortunately, majority of physicians in the current study were not aware of SPIKES.

The results of the study raised issues centered on physician– patient communication. The lack of physicians` knowledge of BBN, lack of effective training of

physicians and prevalent cultural considerations dominating physician-patient communication or a combination of these factors branch out of the core issue. It should be noted that Saudi Arabia has a policy framework that grants certain rights to patients and at the same time expects some responsibilities. This document ensures patients' right to confidentiality; confidential information can only be disclosed if the patient gives explicit consent or if expressly provided for in the law. Information can be disclosed to other healthcare providers only on a strictly "need to know" basis unless the patient has given explicit consent.[25]

It could be deduced from the results that our sampled physicians were aware of the patients' rights, especially the right to know his/her diagnosis and confidentiality. Cultural considerations could strongly influence decision making processes about breaking bad news. Cultures where family bonds are strong and families are predominantly patriarchic, such as Saudi culture, tend to place the decision making with elders of the family without really caring about rights or confidentiality. Physicians have to comply with the cultural norms. This situation is compounded by the lack of training in breaking bad news. It increases the vulnerability of the physician to difficult situations and he or she is likely to find it easier to share patient related information with families or relatives without asking for the patient's permission. Our survey reveals that less than half of the physicians knew that patients is the person that should be given braking bad news and a higher percentage was given to relatives as physicians find it easier to speak to the relatives of patients than the patients themselves. In addition, there is no consistency in physicians` opinion regarding that they should follow the wish of relatives not to inform a competent patient about bad news and they need to judge whether or not to tell a patient bad news. The underlying factor here is the possibility that the physicians are not giving due importance to the patient who is the owner of the information. This has also been found previously in Saudi Arabia.[26, 27]

There are some reported observations of doctors avoiding such a discussion because it distressed them, either they could not handle these issues or they did not have the time to do so adequately. This situation had a negative effect on doctors' emotions and tended to increase patients' distress. This avoidance behavior may result in patients being unwilling to disclose problems, which could delay and adversely impact their recovery. [28] Breaking bad news is stressful for both the patient and the physician and it is quite natural that a physician would avoid it, if he or she could. [29] In the present study, most of the physicians agreed that they felt depressed after breaking bad news to the patient/relatives.

Contrary to what has been reported in another Saudi Study conducted by Al-Mohaimeed and Sharaf,[8] in our study, senior physicians with longer experience had better knowledge scores than seniors. This finding is expected and could be due to the fact that medical schools do not incorporate BBN in the undergraduate curriculum.[30] Traditionally, medical schools devoted more time towards teaching medical skills rather than communication skills. However, this trend should be changed. Modern curricula have realized the importance of effective communication between physicians and are giving due importance to this skill.

Learning to deliver bad news effectively is an important part of providing good medical care, maintaining productive relationships with patients and enhancing patient and physician satisfaction. Therefore, physicians who have attended training courses in BBN showed better knowledge, although it was borderline significant.

One of the significant limitations in this study was the inclusion of primary health care physicians rather than hospital physicians who are more involved in breaking bad news. However, our objective was to assess their knowledge as well as views and experience limited to their field. In addition, the instrument used needed to be improved to

cover more important aspects in patient-doctor communication related to BBN, or an in-depth study on a single aspect.

CONCLUSION

We conclude from the results and discussion of the current study that although the primary physicians are keen to help their patients, most of them lack the essential knowledge and skills of breaking bad news. Older (>45 years old), non-Saudi, more experienced, higher educated, consultant physicians and those attended training courses in breaking bad news were more knowledgeable.

Views of the physicians towards breaking bad news is encouraging as majority of them agreed that patients should be informed about a serious life threatening illness and guidelines or protocols as helpful with respect to breaking bad news. However, about sixty percent of them agreed that Saudi patients would prefer to be told about a serious illness

RECOMMENDATIONS

1- Delivering of breaking bad news can be improved by various simple techniques like paying attention to difficulties to deliver them.
2- Intensive educational interventions to teach skills for delivering bad news (e.g small groups, role-play with feedback, clinical teaching) should be arranged to physicians at all levels.
3- Further research is needed to study this important issue in-depth in our practice, a qualitative study may be more helpful.
4- Breaking bad news should be ideally a skill learned at medical school.
5- Providing quite, private and comfortable locations at hospitals for more effective physician-patient communication.
6- A study to measure the psychological outcomes for patients is warranted to demonstrate improved psychological outcomes because of appropriate delivering of breaking bad news skills.
7- Creating informative guidelines and intervention programs for physicians and other health professionals concerned with the communication of bad news to patients.

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