International Journal of Research in Medical Sciences
Dhage AS et al. Int J Res Med Sci. 2017 Apr;5(4):1617-1621
www.msjonline.org
pISSN 2320-6071 | eISSN 2320-6012
DOI: http://dx.doi.org/10.18203/2320-6012.ijrms20171275

Original Research Article

Breaking bad news of cancer diagnosis - the patient's perspective

Amod S. Dhage[1], Anne R. Wilkinson[2]*

[1]NKP Salve Institute of Medical Sciences and Research Centre, Nagpur, Maharashtra, India
[2]Department of Pathology, NKP Salve Institute of Medical Sciences and Research Centre, Nagpur, Maharashtra, India

Received: 16 November 2016
Accepted: 23 February 2017

***Correspondence:**
Dr. Anne R. Wilkinson,
E-mail: anne_cerry@yahoo.co.in

ABSTRACT

Background: Communication between physicians and patients is a fundamental aspect of cancer care. Bad news could be defined as "any information, which adversely affects an individual's view of his or her future". The aim of the research study was to explore the patient's perspective on receiving cancer news and their expectations regarding the same.
Methods: A cross-sectional study was performed in our tertiary care teaching hospital. 50 consenting cancer patients from 18 to 60 years of age were interviewed on the basis of a structured, validated questionnaire.
Results: On analysis of the 50 patients 'answers, it was found that 37 were females and 13 were males, the average age being 50.07 years. The common diagnosis in females was breast cancer (20 patients) and in males it was lung cancer (5 patients). All the patients wanted relatives present with them when the bad news was broken to them. In 66.6% patients, the news was broken by a junior resident, 15% of the doctors didn't greet the patients, 10% of the patients were told the news suddenly, while 99% of the doctors didn't explain any positive aspects of the disease related to the treatment outcome.
Conclusions: This study provides an insight into the expectations of patients from their physicians with regard to the process of breaking bad news.

Keywords: Bad news, Cancer, Patients perspective

INTRODUCTION

Communication between physicians and patients is a fundamental aspect of cancer care, especially when bad news is being communicated. Clinicians in the field of oncology are invariably forced to break bad news. Communication is often defined as "to impart" or "make known," but its Latin derivation is helpful in highlighting the "sharing" of information; communis means "in common." Bad news could be defined as "any information, which adversely and seriously affects an individual's view of his or her future".[1] Breaking cancer news or any bad news is an uphill task for many of the medical professionals. It is a complex skill as, in addition to the verbal component, it also requires the ability to recognize and respond to the patients' emotions, dealing with the stress that the bad news creates and yet still being able to involve the patient in any decisions, and maintaining hope where there may be little. Similarly, receiving bad news is a stressful task for the patients, as many a times; it virtually alters his or her future.

There is a great need to train physicians in breaking bad news according to the patient-centered communication style. However, training efforts are only helpful, if patients indeed profit from such a patient-centered interaction style when receiving bad news. Hence, instead of focusing on what physicians think their patients want,

the patients' perspective should be considered more important for research purposes.

Open communication between a physician and patient is very important for developing a therapeutic relationship, gathering data, and executing a treatment plan. This level of communication requires mutual trust and respect as well as good listening skills. Though the main aim of communication is to draw and generate information, the way that it is accomplished can have a serious effect on the relationship between the doctor and the patient. It also has an effect on patient's approach to his or her disease and treatment. Good communication remains one of the most important effects on the quality of medical practice as it improves the accuracy of diagnosis, enables better management of decisions and reduces unnecessary investigations and inappropriate treatment.

Physicians and patients might face some barriers while communicating with each other. Some of the barriers which may limit the patient to discuss a concern with his or her physician are social status, race, age, gender, embarrassment, guilt, fear.[2] Often, the best way to overcome these barriers is to define and explore them.

In the developed western countries, there is a general awareness about cancer which may be due to high level of literacy whereas in the developing countries, especially India, rural patients lack awareness regarding cancer and hence their expectations towards receiving cancer news might be different.

Aims and Objectives

To explore the patients' perspective of receiving news about cancer.

METHODS

The study was carried out in our tertiary care teaching hospital. It was a cross-sectional study.

Institutional Ethical Clearance (IEC) for this study was obtained. The study population consisted of all the consenting diagnosed cancer patients associated with our tertiary care teaching hospital in a period of 2 months. Consenting cancer patients from 18-60 years of age were included.

All consenting cancer patients were explained about the objectives of the study. After assuring anonymity, a written consent was obtained. A structured, validated questionnaire was used as the method to find out information.

RESULTS

On analyses of 50 patients' answers, it was found that: Average age of patients was found to be 48.69 years.

Table 1: Age and sex distribution.

Age	Male	Female
21-30 years	-	3
31-40 years	2	8
41-50 years	3	8
51-60 years	3	9
61-70 years	5	9

Table 2: Occupation in females.

Occupation	Frequency	Percentage
Housewife	27	72.97
Maid	6	16.21
Farmer	2	5.4
Nurse	2	5.4

The most common occupation in females was found to be housewife.

Table 3: Occupation in males.

Occupation	Frequency	Percentage
Farmer	4	30.76
Laborer	3	23.07
Driver	2	15.38
Peon	2	15.38
Plumber	1	7.69

The most common occupation in males was found to be farmer.

Table 4: Diagnosis in females.

Diagnosis	Frequency	Percentage
Carcinoma breast	21	57
Carcinoma cervix	6	16
Carcinoma endometrium	4	11
Carcinoma rectum	3	8
Carcinoma ureter	1	3
Carcinoma tongue	1	3
Carcinoma cheek	1	3

Table 5: Diagnosis in males.

Diagnosis	Frequency	Percentage
Carcinoma lung	6	46
Carcinoma stomach	3	23
Carcinoma tongue	1	8
Carcinoma penis	1	8
Carcinoma supra glottis	1	8
Carcinoma thyroid	1	8

The most common diagnosis in females was found to be carcinoma breast (Table 4). The common diagnosis in males was found to be carcinoma lung (Table 5). On analysis of present study, it was observed that all the

patients in present study preferred to have relatives present with them while the bad news was broken to them by the doctors (Table 6).

Table 6: Patients' response.

Patients' response	Frequency	Percentage
Patients preferred a doctor of the same gender as them	5	10%
Wanted relatives present with them	50	100%
Cancer news was broken by junior doctors	34	68%
Doctors did not greet the patients	8	16%
Doctors did not speak in a language which patient could understand	5	10%
Doctors broke the news suddenly	5	10%
The patient wanted to know what the disease would do in their body	47	94%
Doctors did not outline the treatment options available to the patient	12	24%
Doctors did not explain the positive aspects of the disease	49	99%
Doctors did not invite questions about the diagnosis	10	20%

It was also found that as most of the times junior doctors broke the news about cancer diagnosis to the patient, the positive aspects of the disease were not emphasized.

From the patient point of view, it was found that the patients were particularly interested in what the disease would do in their body.

Table 7: Patients' concerns.

Patients' concern	Frequency	Percentage
Fear of how the disease will affect day to day activities	47	94%
Fear of financial burden	42	84%
Fear of how the family would cope	20	40%
Fear of what the disease will do in their body	30	60%
Fear of treatment options	43	86%

As most of the patients in present study came from a low socioeconomic background, financial burden was among the first thought that came into their mind after the cancer news was broken to them. Majority of the patients also feared of how the disease will affect the day to day activities of their lives and the fear of treatment options.

DISCUSSION

Surveys conducted from 1950 to 1970, when there was a lack of research of cancer treatment, revealed that most physicians considered it inhumane to disclose the bad news of cancer diagnosis to the patient.[3,4] While treatment advances have changed the course of cancer so that it is much easier now to offer patients hope at the time of diagnosis, they have also created a need for increased skills of clinicians in discussing other bad news. Earlier, the health care professionals used to withhold information from the patients, because it was believed to be in the best interests of the patient.[5] Nowadays, clinicians share more and more information with patients about the spread of tumour, course of the disease, treatment options and what the treatment would do in their body. Studies indicate that the patients increasingly want additional information regarding their diagnosis, their chances of cure, the side effects of therapy and a practical estimate of how long they have to live.[6,7] Patients expect bad news to be told to them in person, in a private setting and with adequate time for discussion. Literature review suggests that an ideal location for a physician to break bad news is one that is comfortable, quiet, with minimum interruptions and large enough to accommodate multiple staff and family members, if they are present.[8]

The manner in which the physicians communicate the bad news concerning cancer vastly affects the degree of patient's distress in response to the news.[9-11] If bad news is communicated badly it can cause confusion, long-lasting distress, and dissatisfaction; if done well, it can help in understanding, acceptance, and adjustment.[12] The limited existing research about the patient's perspective has almost entirely focused on what kind of information patients want to receive rather than on how patients want this information to be conveyed.[13] Moreover, research regarding how patients want to receive the bad news is either non-empirical or focus on only one outcome of the patient (e.g., patient satisfaction).[14-16]

Studies suggest that a number of factors, apart from a lack of knowledge, can affect a doctor's ability to convey bad news sensitively. Some of the factors that can affect a doctor's ability to convey bad news are long working hours, fatigue, personal difficulties, reaction of the patient, subjective attitude such as personal fear of death.[17,18] The complex nature of the interaction can sometimes create serious miscommunications [19-22] such as patient misunderstanding about the prognosis of the illness or purpose of care.[19-28]

A systematic review and analysis has demonstrated that attending a communication skills training course has a moderate effect on communication behaviour and attitudes but there is a gap in research with few studies investigating patient outcomes. Hence further studies in clinical practice are required in this regard.[29] Several associations have been found between physician's

support and the patient's attitude towards the cancer.[30] On the other hand, the problems physicians face when communicating bad news to their patients include a lack of sufficient time, being honest without causing distress, dealing with the patients' families, responding to the patients' emotions and discussing life expectancy.[31-33]

Because of the above issues, communication between the patients and their physicians need to be improved, but physicians lack knowledge with regard to the optimal way to approach the communication of bad news.[34] Since patients' preferred manner of communication of bad news by physicians, has recently been shown to be related to a lower level of psychological distress, and a higher level of patient satisfaction, some recent studies have focused on preferences of communication style, such as what information to give and how to convey it.[35]

This study provides a valuable local perspective about the patient's expectations and perceptions with regard to the bad news broken to them about cancer by their physicians. Overall, our patients were satisfied with the communication regarding cancer diagnosis. The results suggest that several recommendations made in the literature such as breaking the news gradually, focusing on positive aspects, may be important in disclosing the diagnosis in a way which will optimize the patient satisfaction and psychological wellbeing.[35-38]

Several protocols such as ABCDE (A: Advance preparation, B: Building a therapeutic environment, C: Communicate well, D: Deal with patient reaction, E: Encourage) and SPIKES (SPIKES - S: Setting up the interview, P: Assessing the patient's Perception, I: Obtaining patient's Invitation, K:Giving Knowledge to the patient, E: Addressing the patient's Emotions, S: Strategy and Summary) must be followed to deliver the cancer news.[1] Maintaining straightforward communication with the patients and their families regarding all aspects of the disease lays a basic foundation of confidence and trust between the patient and the health care team. The research findings of this survey could therefore, bridge the gap between patient's expectations and doctors' practices, providing valuable information with respect to patient's perspective about bad news and how it can be optimally broken.

CONCLUSION

This study provides an insight into the knowledge, perceptions and expectations of patients from their physicians with regard to the process of breaking bad news. It is clear that our patients wanted bad news to be broken to them by their physicians in the presence of their relatives in a compassionate manner. They wanted a clear picture of their future and also the prognosis of the disease. It was sometimes also found that the doctors did not invite questions about the diagnosis and they did not speak in a language which the patient could understand. Hence, based on the patients' preferences, suggestions may be offered to the physicians to implement protocols in breaking bad news of cancer diagnosis to patients. Based on the findings of this study, majority of the times, the cancer news was broken to the patients by the junior doctors (residents). Hence, we could train our clinical residents with proto-cols such as SPIKES to improve the way they break the bad news to the patients.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. Buckman R. How to Break Bad News: A guide for healthcare professionals. New England J Med. 1992;329:223.
2. Quill TE. Recognizing and adjusting to barriers in doctor-patient communication. Ann Intern Med. 1989;111:51-7.
3. Oken D. What to tell cancer patients: a study of medical attitudes. JAMA. 1961;175:1120-8.
4. Friedman HS. Physician management of dying patients: an exploration. Psychiatry Med. 1970;1:295-305.
5. Holland JC. Now we tell- but how well. J Clin Oncol. 1989;7:557-9.
6. Meredith C, Symonds P, Webster L, Lamont D, Pyper E, Gillis CR, et al. Information needs of cancer patients in west scotland: cross sectional survey of patient's views. BMJ. 1996;313:724-6.
7. Ley P. Giving information to patients. In: Eiser Jr ed. Social psychology and behaviour science 14th ed. New York: Wiley and Sons Ltd; 1982;353.
8. Peteet J, Abrams H, Ross DM, Stearns NM. Presenting a diagnosis of cancer patients' views. J Fam Pract. 1991;32:577-81.
9. Takayama T, Yamazaki Y, Katsumata N. Relationship between outpatients' perceptions of physicians' communication styles and patients' anxiety levels in a Japanese oncology setting. Soc Sci Med. 2001;53:1335-50.
10. Schofield PE, Butow PN, Thompson JF, Tattersall MH, Beeney LJ, Dunn SM. Psychological responses of patients receiving a diagnosis of cancer. Ann Oncol. 2003;14:48-56.
11. Morita T, Akechi T, Ikenaga Y, Kizawa Y, Kohara H, Mukaiyama T, et al. Communication about the ending of anticancer treatment and transition to palliative care. Ann Oncol. 2004;15:1551-7.
12. Bain MG, Lian CW, Thon CC. Breaking bad news of cancer diagnosis- perception of the cancer patients in a rural community in Malaysia. South Asian J Cancer. 2014;15:3-4.
13. Jenkins V, Fallowfield L, Saul J. Information needs of patients with cancer: results from a large study in UK cancer centres. Brit J Cancer. 2001;84:48-51.
14. Parker PA, Baile WF, de Moor C, Lenzi R, Kudelka AP, Cohen L. Breaking bad news about cancer:

patients' preferences for communication. J Clin Oncol. 2001;19:2049-56.
15. Salander P. Bad news from the patient's perspective: an analysis of the written narratives of newly diagnosed cancer patients. Soc Sci Med. 2002;55:721-32.
16. Ptacek JT, Ptacek JJ. Patients' perceptions of receiving bad news about cancer. J Clin Oncol. 2001;19:4260-4.
17. Brown R, Dunn S, Byrnes K. Doctors' stress responses and poor communication performance in simulated bad-news consultations. Acad Med. 2009;84(11):1595-602.
18. Cialkowska-Rysz A, Dzierzanowski T. Personal fear of death affects the proper process of breaking bad news. Arch Med Sci. 2013;9(1):127-31.
19. Ptacek JT, Eberhardt TL. Breaking bad news. A review of the literature. JAMA. 1996;276:496-502.
20. Lind SE, DelVecchio-Good MJ, Seidel S. Telling the diagnosis of cancer. J Clin Oncol. 1989;7:583-9.
21. Taylor C. Telling bad news: physicians and the disclosure of undesirable information. Social Health Illn. 1988;10:120-32.
22. Miyaji N. The power of compassion: truth-telling among American doctors in the care of dying patients. Soc Sci Med. 1993;36:249-64.
23. Eidinger RN, Schapira DV. Cancer patients' insight into their treatment, prognosis and unconvential therapies. Cancer. 1984;53:2736-40.
24. Mackillop WJ, Stewart WE, Ginsberg AD. Cancer patients' perceptions of their disease and its treatment. Br J Cancer. 1988;58:355-8.
25. Quirt CF, McKillop WJ, Ginsberg AD. Do doctors know when their patients don't? A survey of doctor-patient communication in lung cancer. Lung Cancer. 1997;18:1-20.
26. Siminoff LA, Fetting JH, Abeloff MD. Doctor-patient communication about breast cancer adjuvant therapy. J Clin Oncol. 1989;7:1192-200.
27. Weeks JC, Cook EF, O'Day SJ. Relationship between cancer patients' predictions of prognosis and their treatment preferences. JAMA. 1998:279;1709-14.
28. Haidet P, Hamel MB, Davis RB. Outcomes, preferences for resuscitation, and physician-patient communication among patients with metastatic colorectal cancer. SUPPORT investigators. Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments. Am J Med. l998;105:222.
29. Barth J, Lannen P. Efficacy of communication skills training courses in oncology: a systematic review and meta-analysis. Ann Oncol. 2011;22(5):1030-40.
30. Uchitomi Y, Mikami I, Kugaya A, Nakano T, Okuyama T, Akechi T, et al. Physician support and patient psychologic responses after surgery for nonsmall cell lung carcinoma: a prospective observational study. Cancer. 2001;92:1926-35.
31. Baile WF, Lenzi R, Parker PA, Buckman R, Cohen L. Oncologists' attitudes toward and practices in giving bad news: an exploratory study. J Clin Oncol. 2002;20:2189-96.
32. Fujimori M, Oba A, Koike M, Okamura M, Akizuki N, Kamiya M, et al. Communication skills training for Japanese oncologists on how to break bad news. J Cancer Educ. 2003;18:194-201.
33. Barnett MM. Effect of breaking bad news on patients' perceptions of doctors. J R Soc Med. 2002;95:343-7.
34. Uchitomi Y. Psycho-oncology in Japan: history, current problems and future aspect. Jpn J Clin Oncol. 1999;29:411-2.
35. Schofield PE, Butow PN, Thompson JF, Tattersall MH, Beeney LJ, Dunn SM. Psychological responses of patients receiving a diagnosis of cancer. Ann Oncol. 2003;14:48-56.
36. Girgis A, Sanson-Fisher RW. Breaking bad news: consensus guidelines for medical practitioners. J Clin Oncol. 1995;13:2449-56.
37. Ptacek JT, Eberhardt TL. The patient-physician relationship. Breaking bad news: a review of the literature. JAMA. 1996;276:492-6.
38. Fallowfield L. Giving sad and bad news. Lancet. 1993;341:476-8.

Cite this article as: Dhage AS, Wilkinson AR. Breaking bad news of cancer diagnosis - the patient's perspective. Int J Res Med Sci 2017;5:1617-21.