

Perception and Attitude towards Breaking Bad News in the Saudi Population

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Abstract

Breaking bad news is considered one of a physician's most difficult duties. Discomfort and uncertainty associated with breaking bad news, along with a lack of proper training, may lead physicians to emotionally disengage from patients.

The aims of this study were to evaluate the patients' beliefs of bad news and their perception and attitude towards breaking bad news. A cross sectional community based survey was conducted in Riyadh city during the month of April, 2009. A representative sample was selected using a stratified random sampling technique. A validated self administrative questionnaire in Arabic language was designed and used for data collection. Chi Square test was used to find the association between two qualitative variables. P- Value was set to be < 0.05 throughout the study.

The study included 1086 participants. Half of the samples were male and 46% of them were between 30-39 years old. Almost 75% of them defined bad news as related to the diseases that are highly fatal. Only 50% of the participants had a satisfactory experience in the method of breaking bad news. Around 81% of participants insist on being informed about any news related to their health. Educational level seems to be one of the influencing factors ($p < 0.001$). Most of the participants (71.1%) want detailed information about the disease. Most of the patients (i.e. 88.2%) appreciate more those who tell them the truth.

The study gave an overview of Saudi Citizens' perceptions towards breaking bad news. In general, participants had a good understanding of the situation and respect honesty. Medical professionals are urged to learn more about the importance and the techniques of breaking bad news to gain patient's satisfaction and build sound doctor-patient relationships.

Key words: Breaking Bad News, Terminal patients, Communication and Saudi Arabia

Introduction

In *Decorum*, Hippocrates advised(1) "Reveal nothing to the patient of his future or present condition for this has caused many patients to take a turn for the worse". Unfortunately this tradition of silence persisted for centuries. In the past few decades, this has changed. A review of studies on patient preferences regarding disclosure of a terminal diagnosis found that 50-90% of patients desired full disclosure(4).

Communicating bad news is an essential skill for physicians. (However), the vast majority of Americans want to know if they have a life-threatening illness. Although legitimate cultural variations are important, breaking bad news in a direct and compassionate way can improve the patient's and family's ability to plan and cope, encourage realistic goals and autonomy, support the patient emotionally, strengthen the physician-patient relationship, and foster collaboration among the patient, family, physicians, and other professionals.

The breaking of bad news (BBN) is an emotive subject for both health professionals and patients and it is one of the most difficult responsibilities in the practice of medicine(1). Many find it challenging to convey bad information, especially when this involves a life-threatening illness. Others fear the news will be distressing and adversely affect the patient, family, or the therapeutic relationship. Physicians have reported that breaking bad news was moderately stressful for them, and the stress lasted beyond the recalled transaction and they admit to having difficulty with it(2,3).

Various studies had defined bad news as "any news that drastically and negatively alters the patient's view of their future."(1,4-8) Another definition of bad news is that "it results in a cognitive, behavioural, or emotional deficit in the person receiving the news that persists for some time after the news is received"(9). Thus, the determination of what news is bad constitutes a subjective judgment in the mind of the receiver(9).

Breaking bad news has been ignored in the past and still depends largely on culture and social state(10). Although virtually all physicians in clinical practice encounter situations entailing bad news, medical school offers little formal training in how to discuss bad news with patients and their families(1). 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 afraid of the patient's or family's reaction to the news, or uncertain how to deal with an intense emotional response(1). The overall view is that a positive or negative bad-news experience can affect a patient's subsequent adjustment(9).

Physicians vary in their confidence to break bad news. In a survey done in various teaching hospitals of Pakistan, only 60% of doctors thought that they had conveyed the bad news properly; 26% of them had conveyed the news to the families and not to the patients(4). In another study, the physicians believe that they were effective in delivering the news in a way that reduced a patient's distress(2). In fact, the issue of how to disclose the truth is more important than whether or not to do so. There are many recommendations on how a cancer diagnosis should be revealed to the patients. Everyone has stressed the importance of honesty, compassion, sensitivity, clarity, and allowing some measure of hope(11).

Adequate preparation with effective communication skills, empathy, and planned follow-up are considered essential steps to assure that the goals for these difficult interactions are met(5). Effective communication between the doctor and patient forms an essential crux of breaking bad news. It is central to the delivery of high quality medical care and has been shown to affect patient satisfaction, decrease the use of pain killers, shorten hospital

stay and improve recovery from surgery and a variety of other biological, psychological and social outcomes(4).

A patients' culture and beliefs play a major role in the guidance of health care providers to select the appropriate method of revealing bad news. These views have not been studied before in Saudi Arabia. Therefore this study has been designed to evaluate the patients' beliefs of bad news and their perception and attitude towards the manner in which this news has been delivered to them.

Methodology

A cross sectional study was conducted during the month of April 2009 in Riyadh, the capital city of Saudi Arabia, which is the largest city in the country with a total population exceeding five million. As capital of Saudi Arabia, Riyadh has received millions of visitors of different nationalities and cultural backgrounds. The population of Riyadh consists of 60% Saudis with the rest being from other nationalities.

The sample size has been calculated to be 865 subjects at a 95% confidence interval and 5% sample error, assuming a 50% variance. To accommodate for dropout and non-participant rate the sample size was increased to 1000. Using stratified random sampling, only adults were selected to participate in this study due to its nature. The targeted population was stratified based on different age groups and availability in the community. Those between twenty to thirty were selected in universities and other public areas; whereas those above thirty were selected by surveying work and public areas like ministers, companies, hospitals, airport, malls and other locations. Required permission was taken from the concerned administrative departments and ministries to administer the questionnaires. Informed consent was taken from all the subjects participating in the study, when they were given the questionnaire. Moreover,

ethical approval was given by the institutional review board, at the Medical Research Centre, King Saud University.

A self administered questionnaire in Arabic language was prepared, based on the questionnaire used in reviewed previous studies, in a manner that signified the study research goals in a clear way. The questionnaire for this study consisted of fourteen items. Seven of them were concerned with the demographic characteristics (Age, sex, nationality, educational level, occupation, residency and marital status) and the remaining questions were about definition of bad news, the participant's evaluation of the way the health team conveyed bad news, the participant's opinion on receiving bad news, including their willingness to receive medical treatment with or without knowing the diagnosis and the amount of

information they need to know about the case after breaking bad news. The last three questions were concerned with the respondents' reaction as to if the treating physician withheld or provided the diagnosis, and the expected immediate reaction after receiving bad news.

The questionnaire had been validated via a pilot study on fifty individuals from the society and reviewed by five experts. The appropriate modification was made based on the pilot study.

Data was collected by the researchers and research assistants who were trained by illustrating to them the research objectives and appropriate data collection method. The response rate from the society was approximately 90%. Questionnaires that were not fully completed were eliminated.

The data was analysed via SPSS program version(16). Frequency distribution was applied for all variables. Chi square test was used to find associations among qualitative variables and an alpha level of 5% was taken for statistical significance.

Ethical considerations, such as informed consent and confidentiality of the subject, were ensured.

Results

A total of 1086 individuals participated in this study. All the respondents completed full interviews which were used for primary analysis. The initial questionnaire was developed based on the prior experience of investigators, input from colleagues and peers, as well as patients. The initial framework of the questionnaire was then expanded by incorporation of new aspects encountered during an extensive literature search.

Variable	%	No	Variable	%	No
Age			Education		
20-29	25.5	277	Primary	2.2	24
30-39	45.9	498	Intermediate	7.5	81
40-49	16.8	182	Secondary	29.2	317
50-59	8.8	96	Diploma	15.1	164
60+	3	33	University	40.6	441
Sex			Post Graduate	5.4	59
Male	48.2	523	Occupation		
Female	51.8	563	Military	2.9	31
Nationality			Governmental Employee	24.3	264
Saudi	93.3	1013	Private Employee	16.4	178
Non-Saudi	6.7	73	Student	50.3	546
Marital Status			Retired	6.2	67
Single	63.2	686	Residency		
Married	36.8	400	City	97.7	1061
			Village	2.3	25

Table 1: Characteristics for the study participants

Among the participants 25.5% were below 30 years of age, 45.9% were between 30-40 years of age, 16.8% were between 40-50 years and only 11% were above the age of 50 years. The gender distribution in the selected sample was almost equal with males being 48.2% and 51.8% females. As the study was conducted in Saudi Arabia, the majority of the participants (93.3%) were Saudi and almost the entire sample (97.7%) was taken from the urban population. The minimum educational qualification of the sample was at least intermediate school, with 29.2% having Diploma, and the highest 40.6% were postgraduate and 4.6% had a doctorate degree. Among the participants only 36.8% were married and the remaining unmarried.

Around 50.3% of subjects who participated in this study were students; 24.3% were working in government agencies, and 16.4% of the subjects either had their own business or were working in private institutions.

The majority of the respondents (74.8%) had a fairly accurate idea of what "bad news" is and defined it as "having a disease which leads to death".

Table 2 presents the participant's responses towards the perception variables associated with breaking bad news. Around 42.2% of the respondents were satisfied with the way the health team conveyed the bad news, against 20.9% who were not satisfied. In response to the question regarding their preferences whether the physician who broke the bad news should treat them or not, 81.25% of the respondents' answers were affirmative while only 18.9% stated they would prefer to be treated without knowing it.

In response to the required information about their condition the vast majority (71%) expressed their desire, that all the details must be discussed with them in greatest details.

Denial (10.8%), sadness/depression (34.7%), and acceptance (35.3%)

were amongst the most intense emotions experienced by them when the bad news was broken to them.

In response to the question, whether their trust shall be affected, if the physician chooses not to inform them about their actual condition, 34.5% of the participants responded by stating that it will affect their relationship, while 36% said it will have no effect on their relationship. And a whopping majority, around 88.2% of the respondents stated they would appreciate and respect the physician who had conveyed the bad news to them.

The relationship between various variables and their interactions with attitude, perception, and experience towards breaking bad news, are presented in Table 3 (page 20).

We found a significant association in the relationship between age, education level as well as gender of the respondents and type of emotional response expressed on hearing bad news ($p=0.001$). Also, the association between age and opinion (that age makes a difference in the reception of bad news) was found to be significant ($p=0.000$). The association between gender and opinion was also significant ($p=0.000$).

Evaluating the way health team members convey bad news was significantly related to education ($p < 0.001$). Satisfaction rate was higher in the highly educated versus less educated, 61.4% vs. 52.5% respectively. About 85% of those who were highly educated preferred to be treated by the physician after he/she conveyed them the bad news significantly more than the less educated (75.6%); ($p < 0.001$).

The highly educated, as expected, insisted on knowing detailed information about their case after the diagnosis more than those with less education ($p = 0.001$). There was no difference found regarding "needing to know more information about the person's case" in relation to sex and age.

A significant difference ($p = 0.04$) was found in the immediate reaction of "not believing" after breaking of bad news between younger and older participants and also between the elderly males and females ($p = 0.037$), with females showing more disbelief.

The acceptance of the bad news was also significantly different between older (35.0%) and younger (17.0%) participants. A similar difference was also found between male and female participants (28.1% vs. 16.7%); ($p < 0.01$).

Similarly, the younger participants (24.5%) showed significantly more sadness and depression compared to the older participants (15.1%). The female participants expressed significantly more sadness and depression than male participants ($p < 0.01$).

Discussion

The aim of this study was to evaluate the patients' beliefs and perception and attitude towards breaking bad news.

According to this study, about three quarters of the participants defined bad news as "having a disease that leads to death" which is comparable to the finding of the study by Sidra Ishaque et al. which stated that the majority of the participants had a fairly accurate idea about the connotations and implications symbolized by the term "bad news"(4). Although patient satisfaction ratings, with the way the health team had conveyed the bad news, were quite high, they were similar to other published reports and seem to be consistent with such ratings when survey methods are used (2, 4).

Evidence indicates that patients increasingly want additional information regarding their diagnosis, their chances of cure, the side effects of therapy and a realistic estimate of life expectancy(4). A review of studies on patient preferences regarding disclosure of a terminal diagnosis by Curtis et. al. found that 50-90% of the patients desired full disclosure(1),

Variable	No	%	Variable	No	%
Definition of bad news:			Expectations of immediate reaction when knowing bad news:		
Having any disease	185	17	Denial	74	11
Having non curable disease	432	40	Anger	34	5
Having chronic Disease (e.g. DM)	309	29	Discussion and Arguing	97	14
Having disease that leads to death	813	75	Acceptance	241	35
Don't have clear definition	87	8	Sadness and Depression	237	35
Does the patients' trust of the physician who preferred Not to tell the bad news be affected?			The amount of information they need to know after breaking the bad news:		
Yes	375	35	Need detailed information to be discussed with me	772	71
No	391	36	Only answer my questions	162	15
Not sure	320	30	Brief information about my case	152	14
Evaluation of the way health team conveyed the bad news:			Patients' attitude towards the person who conveys the bad news:		
Good	108	9.9	Trust will be affected	27	2.5
Satisfactory	465	43	Dislike and refuse meeting him/her	70	6.4
Unsatisfactory	227	21	Appreciate and respect him/her	985	88
Don't Know	286	26	Other	31	2.9
Patients' preference if his/her physician has bad news:					
Treating you after telling the news	883	81			
Treating you without telling the news	204	20			

Table 2: Attitude and perception of the study respondents toward Breaking Bad News

which was similar to our participants' preference. On the other hand, in another study, just more than 50% of the patients reported receiving the amount of information they wanted at diagnosis and treatment; though 37% and 34% received less information than they wanted(12). Patient reports about poor delivery are often characterized by bluntness, a lack of hope, and initiation of this serious conversation at an inappropriate time or place (5).

Patients report a variety of emotional reactions to hearing bad news. In a study of patients who were diagnosed as having cancer, the most frequent responses were shock (54%), fright (46%), acceptance (40%), sadness (24%), and "not worried" (15%)(9). In our study respondents' immediate reaction when knowing bad news was between acceptance and

sadness with depression (35.3% and 34.7% respectively), which concurs with the study by Greeg K. Vandekieft which showed that the patient responses to bad news can be influenced by the patient's psychosocial context(1). Another study by Mandy et. al. found that there was no statistically significant association between patients' current psychological morbidity and their perceptions of the bad-news event, in either direction; that is, patients with a positive memory were not protected from depression, and patients with highly negative memories were not more likely to be depressed (15).

Emotional preparation by the provider is an important step prior to delivering bad news. Self-reflection helps to identify personal emotions of sadness, anger, fear, or guilt and will help the provider not to disengage from the delivery of bad news(6). It

is normal to have strong feelings, especially in difficult situations. Encouraging and validating these emotions personally will lead to a more therapeutic presence during a patient's time of need(5).

The attitudes of our respondents when receiving bad news were likely to be influenced by education, age and sex. There are many factors which can influence the attitude of patients when receiving bad news. In a systematic review by Maiko et al. it was found that the younger patients, female patients and highly educated patients consistently desired to receive as much detailed information as possible and to receive emotional support. Younger and highly educated patients also wanted to participate in decisions regarding their treatment(13). One study suggested that having an average income was associated with wanting

Variable	Age				Gender				Education				
	<30		>30		Male		Female		<University		University +		p
	No	%	No	%	No	%	No	%	No	%	No	%	
	P		P		p		p		p		p		
Definition of Bad news <i>Having any disease</i> <i>Having non curable disease</i> <i>Having chronic disease</i> <i>Having disease that leads to death</i> <i>Don't have clear definition</i>	123	15.9	62	19.9	109	20.8	76	13.5	63	14.9	122	18.4	0.14
	305	39.4	127	40.8	211	40.3	211	39.3	142	33.6	290	43.7	0.001
	221	28.5	88	28.3	137	26.2	172	30.6	108	25.6	201	30.3	0.96
	604	77.8	209	67.2	370	70.7	442	78.5	308	73.0	504	75.9	0.28
	61	7.9	26	8.4	46	8.8	41	7.3	39	9.2	48	7.2	0.23
Evaluation of the way the health team conveyed the bad news <i>Good</i> <i>Satisfactory</i> <i>Unsatisfactory</i>	71	13.3	37	13.9	54	10.3	54	9.6	64	21.5	44	8.7	0.001
	321	60.1	144	54.1	244	46.7	221	39.3	156	52.5	309	61.4	
	142	26.6	85	32.0	105	20.1	122	21.7	77	25.9	150	29.8	
Patients' preference if his/her physician has bad news <i>Treating you after telling the news</i> <i>Treating you without telling the news</i>	624	80.5	258	83.0	419	47.5	463	52.5	320	75.8	562	84.6	0.001
	151	19.5	53	17.0	104	52.5	100	48.0	102	24.2	102	15.4	
The amount of information they need to know after breaking bad news <i>Need detailed information to be discussed with me</i> <i>Only answer my questions</i> <i>Brief information about my case</i>	538	69.5	234	75.2	367	70.2	405	71.9	273	35.4	499	64.6	0.001
	122	15.7	40	12.9	77	14.7	85	15.1	78	18.5	84	12.7	
	115	14.8	37	11.9	79	15.1	73	13.0	71	16.8	82	12.2	
Expectations of immediate reaction when knowing bad news: <i>Not believing</i> <i>Anger</i> <i>Discussion and arguing</i> <i>Accept the Bad News</i> <i>Sadness and Depression</i>	62	83.8	12	16.2	27	5.2	47	8.3	33	7.8	41	6.2	0.29
	25	3.2	9	2.9	19	3.6	15	2.7	14	3.3	20	3.0	0.78
	75	9.7	22	7.1	51	9.8	46	8.2	39	9.2	58	8.7	0.77
	132	17.0	109	35.0	147	28.1	94	16.7	90	21.3	151	22.7	0.58
	190	24.5	47	15.1	88	16.8	149	26.5	99	23.5	138	20.8	0.30

Table 3: The relationship between various variables and their interactions with attitude, perception, and experience towards breaking bad news

more information than having a low income(13).

Cross-cultural differences were indicated by some patient's preferences. Only 30% or fewer of patients in Asian studies preferred to discuss life expectancy, whereas 60% of patients in western studies preferred to do so(13). In a study by Young et al. they found that age, religiousness, relationship to patient, time since diagnosis, type of primary cancer, disease stage, and performance status were likely to influence attitudes, while sex, level of education, income, awareness of the cancer, preference for place of care and death, and diagnosis were not(11).

In conclusion, this study shows that male, elderly and high educated people are more receptive to accepting bad news than others. Mostly they showed interest in knowing more information about their case and respected the honesty of the person who revealed this bad news to them.

Our belief was that the nature of these specific transactions would set the stage, positively or negatively, for subsequent interactions between the patient and the physician in the Saudi population. Subsequent research efforts should explore other variables that might influence the quality of patient doctor relationships after bad news and assess both relational and informational factors. This may lead to formulating more appropriate guidelines and training methods, for health care professionals. Additional research should include large-scale, multicentre prospective designs and use of several data sources, which may reveal important predictors in our pursuit of a better standard of care and higher level of patient satisfaction based on Islamic guidance in the Saudi population.

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