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Breaking Bad News Preferences among Healthcare Professionals in Malaysian Government Hospitals

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Abstract

For healthcare professionals, breaking bad news is considered to be difficult and complex. Trial and error, as well as observing seniors, are popular approaches used by healthcare practitioners to improve their skills. These channels of practice are not optimal, and they can have negative consequences for the quality of bad news delivery and overall healthcare. Communication training and the inclusion of breaking bad news models in the curriculum are among the efforts made by the healthcare business to provide skills to healthcare personnel, yet these efforts are found to be insufficient or non-existent. A client-centred approach, which originates from a patient-centred approach, is seen to be effective in assisting healthcare professionals in tailoring their bad news delivery to the needs and preferences of the clients who are the recipients of the news. This study conducted a survey of 100 current practising practitioners to determine their preferences around the delivery of bad news. The data from the survey was analysed using descriptive synthesis analysis. The findings of the study were presented in two main categories: (i) Demographic details and health profiles, and (ii) Breaking bad news preferences. According to the findings, the respondents' preferences for conveying bad news are similar to one breaking bad news model, the SPIKES model. This research is believed to add to the existing literature on practises of healthcare providers when it comes to delivering bad news.

Keywords: Breaking Bad News, Survey, Descriptive Analysis, Breaking Bad News Preferences, Patient-Centred Communication

Introduction

Breaking bad news has been a clinical task that many healthcare professionals could not escape despite how challenging it is especially to those who have direct contact with patients. Bad news is news that can or will change a patient's outlook of his or her future in a very negative way (Buckman, 1984). Bad news includes a declaration of brain death, a withdrawal

of treatment, a prospect of death, or an increase in limitations and many more. Most healthcare professionals that have been entrusted to break bad news are treating physicians, specialists, house officers and sometimes nurses. It is vital to convey bad news in a skilful manner because this is a critical moment in the patient's illness's history that will have immediate or long-term effects in their lives (Mengin et al., 2021). Breaking terrible news has the capacity to either increase or undermine the patient's or recipients' trust in the doctors or bearers of the bad news (Paramasivan & Khoo, 2020). Many have expressed dissatisfaction with doctors' communication abilities rather than their clinical competence. A report from the Royal College of Physicians indicates that poor communication was the major complaint about doctors (Royal College of Physicians, 1997). Clayton et al (2008) later in their study mentioned that patients and caregivers emphasized that the way information is delivered is often as important as, or more important than, the content (pg. 657). They want doctors who can not only diagnose and treat their illnesses, but ones who can also communicate successfully with them. Due to this, the researchers find significance in looking at the preferences of healthcare professionals when communicating bad news to patients or family of patients within the context of Malaysia. This is to reveal patterns in their preferences that will later be a useful input for healthcare stakeholders to be informed with the current practices of healthcare professionals when it comes to breaking bad news. This information will assist the stakeholders to better plan the syllabus of courses or training related to breaking bad news. Therefore, this study aims to investigate the preferences of healthcare professionals when breaking bad news.

Literature Review

Healthcare professionals giving bad news must adopt a flexible approach based on each individual's wishes and needs. This necessitates a patient-centred communication approach. It is a client-specific approach that emphasises the necessity of offering clear "knowledge, realistic goals, advice, and encouragement" (Oikonomidou et al., 2017, pg. 8) while also paying close attention to the clients' needs, the clients' understanding of the situation, and expressing empathy where necessary. This is why this approach in the healthcare industry is becoming increasingly popular. This is because, when bad news is inadequately communicated, the negative impacts on the clients (the recipients of the news) are difficult to undo (Ptacek & Eberhardt, 1996). As a result, it is critical for healthcare professionals to grasp what constitutes successful bad news delivery from the perspective of patients. Traditionally, the doctor has dominated decision-making, with little respect for the feelings of the recipients of the news but now, the recipients are expected to participate meaningfully in the decision-making process. This study however will use the term "client-centred" approach rather than patient-centred approach as those receiving the news, do not necessarily be the patient themselves, families and caregivers are also included.

Many models or recommendations are found to be introduced to healthcare practitioners while performing the task of breaking bad news. As asserted by Mostafavian and Shaye (2018), it is imperative for physicians to find an appropriate way for breaking bad news because it can help recipients understand and influence their outlook and attitudes on the news. Among breaking bad news models available are SPIKES, COMFORT, Kaye's 10 steps, BREAKS, ABCDE, PEWTER and many more. One of the most often utilised models on the market is the SPIKES model (Igier et al., 2015; Oikonomidou et al., 2017; Seifart et al., 2014). Even though there are different models for imparting bad news, Abdul Hafidz and Zainudin

(2016) claimed that observing sessions conducted by experienced physicians is the best way to learn. The researchers disagree, believing that physicians should be equipped with the necessary knowledge and skills by not only observing senior colleagues, but also completing communication training and being aware of various models that can help them function better in situations where bad news is delivered.

Buckman's (1984) SPIKES, a six-step method introduced in 1982, was extended by Baile et al (2000, pg. 305-308), as shown in Appendix A. The abbreviation SPIKES stands for six steps that should be followed while delivering unpleasant news: (1) Setting, (2) Perception, (3) Invitation, (4) Knowledge, (5) Empathy, and (6) Summary. A recent study made by Sharif and Ibrahim (2021) who studied four sequential models of breaking bad news: SPIKES, Kaye's 10-step, ABCDE, and BREAKS, that are commonly utilised by healthcare professionals found that breaking bad news comes in five major themes. The themes are "(1) Prepare for the breaking bad news session, (2) Explore the recipients' state of knowledge, (3) Communicate the bad news, (4) Attend to the recipients' reactions to the news, and (5) Summarise the session" (pg. 32). These five themes are believed essential for healthcare professionals to be aware of as they can be components that they need to make sure to try their best to incorporate in their breaking bad news sessions rather than not have any clue of how to go about breaking the news to the recipients. The researchers however argue that these themes may not come in a standard sequential manner and every breaking bad news session may not have all themes or new themes might emerge from the session.

Based on these five main themes, the researchers then decided to detail out each theme into a few sub themes. The researchers identified most recurring sub-themes mentioned in the four breaking bad news models (as laid out in Sharif and Ibrahim, 2021, pg. 29-31) and resulted in 10 sub-themes which are known as breaking bad news items in the survey. Appendix B reveals the recurring subthemes for each theme by marking them as present (+), absent (-), or barely addressed (+/-). The identification of subthemes is thought to be critical for physicians to better comprehend the function of each theme. In this study, professionals were approached online to participate in this study, and after receiving their consent, a survey was emailed to them. The survey requires them to reflect upon their opinions and practices of breaking bad news. This study aims to investigate the healthcare professionals' preferences of breaking bad news and use of breaking bad news models.

Method and Analysis

A cross-sectional study was undertaken from October 2019 to December 2022. A self-administered questionnaire (can be referred in Appendix C) was used to gather data on healthcare professionals' knowledge and practices when it came to conveying bad news to patients and their families. SPSS (Statistical Package for Social Sciences) version 23 and Microsoft Excel were used to analyse the data. SurveyMonkey was used to conduct the online surveys. The information gathered was kept secure and confidential, and it was solely utilised for research reasons. To characterise the data pattern, descriptive statistics were used. As stated by (Mazalan et al., 2021), descriptive analysis has the ability to evaluate qualities of respondents and also reveal potential contributing elements. This is why apart from inferential analysis, it is one of the primary methods to statistical technique utilised in the health-care industry, as well as in other areas (Kaur et al., 2018). The raw data from a sample or population is summarised using descriptive analysis, revealing means and frequencies.

Sample

This study's respondents were chosen using a random purposive sampling method. Only individuals who have direct contact with patients were asked to complete the survey, regardless of which departments they serve, for example, medicine, paediatrics, oncology, surgery, or emergency). Over the course of three months, the researchers collected a hundred questionnaire responses. The researchers contacted 150 healthcare professionals, and after receiving 100 responses, she ceased distributing invites and closed the survey link responses. On October 1, 2021, the questionnaires were emailed to the respondents. One reminder email was sent to respondents after three weeks. On December 13, 2021, the data collection was completed. The findings of the survey were saved in the online survey database. All the questions were answered by the respondents, with no missing information in any of the survey responses.

Results

Demographic Details and Health Profiles

The majority of respondents were female (74%) and only 26% of them were male. Most of them had 0 to 5 years of work experience (58%), followed by 5 to 10 years of work experience with 23 % and more than 10 years of work experience with 19%. As for work discipline, 39% of them are medical officers, followed by others (33%) who are mostly designated by the respondents as assistant medical officers and house officers. Specialists made up 15% of the respondents, postgraduates made up 13%, and nurses made up none of the respondents. Table 1 summarises the demographics of survey respondents.

Table 1
Demographic details and health profiles (n = 100).

No	Item		Percentage (%)
1	Gender	Male	26
		Female	74
2	Years of working with the hospital / healthcare industry	0 to 5 years	58
		5 to 10 years	23
		More than 10 years	19
3	Medical discipline.	Specialist	15
		Medical Officer	39
		Postgraduate Student	13
		Nurse	0
		Others	33 - House Officer (15) - Assistant Medical Officer (1) - Not mentioned (27)

Breaking Bad News Preferences

These sections are developed by the researchers to see the respondents' adherence to the steps or items suggested by the breaking bad news models. The adherence discloses their preferences when breaking bad news. The preference to deliver bad news had 76 responses out of a total of 100 as 76 respondents were led to this section since they had experience delivering bad news. In general, the results show that respondents seemed to attend to all

the breaking bad news items as the 'Yes' scores were all higher (mean score= 87.6%) than 'No' (mean score= 4.3%) and 'Sometimes' (mean score= 7.8%).

Looking at the ten items, there are four items that scored 94% and above as respondents saying 'Yes' to them. The biggest number of respondents preferred to use appropriate language or layman' language when breaking bad news (Item 6) with 98.7%, followed by Item 1, which they make sure to get themselves informed of the patient's medical conditions before breaking bad news (97.4%). Item 3, in which they assess the recipients' knowledge and perception of the patient's medical condition and Item 8, in which they show support and understanding to the recipients, shared a similar score which is 94.7%. Another 5 items (Item 2, 4, 7, 9 and 10) also showed a great number of respondents put such items into their breaking bad news which signal their preferences. These items ranged from 80.3% (Item 2 & 9) to 88.2% (Item 7). Item 5, which is providing hints before disclosing the bad news on the other hand showed the lowest score with 71.1%. Even with the lowest score, it still demonstrates that the majority of respondents prefer to have it in their practises when they answered 'Yes' compared to 10.5% for 'No' and 18.4% for 'Sometimes'. This result also reveals that the respondents answered, 'Sometimes' more than 'No', which could indicate that they still use it in their routines but not on a regular basis, implying that it is not necessarily something they do not prefer. Table 2 summarises the results of the preference to deliver bad news among healthcare professionals.

Table 2
Preferences when delivering bad news (n=76)

No	Item		Yes		No		Sometimes	
			n	**%**	**n**	**%**	**n**	**%**
1	Prepare for the breaking bad news session	Get informed of the patient's medical conditions before breaking bad news	74	97.4	2	2.6	0	0.0
2		Prepare a private/comfortable place to break bad news	61	80.3	3	4.0	12	15.8
3	Explore the recipients' state of knowledge	Assess the recipients' knowledge and perception of the patient's medical condition	72	94.7	2	2.6	2	2.6
4		Find out what and how much the recipients want to know	64	84.2	4	5.3	8	10.5
5	Communicate the bad news	Provide hints before disclosing the bad news	54	71.1	8	10.5	14	18.4
6		Using appropriate language/'layman' language to break bad news	75	98.7	1	1.3	0	0.0
7	Attend to the recipients' reactions to the news	Allow recipients to express their feelings and emotions after receiving the news	67	88.2	2	2.6	5	6.6
8		Show support and understanding to the recipients (e.g.: empathetic remarks)	72	94.7	4	5.3	0	0.0
9	Summarise the session	Summarise the session	61	80.3	4	5.3	11	14.5
10		Explain future plans regarding the patient's conditions	66	86.8	3	4.0	7	9.2
Mean score (%)			87.6%		4.3%		7.8	

Discussion

The Preferences of Healthcare Professionals when Breaking Bad News

According to Mohd Sharif and Ibrahim (2021), there are five essential elements to conveying bad news, and the findings of this study support these themes, as all respondents include these topics when breaking bad news. The researchers then divided each theme into two sub-themes to aid respondents in finding connections between the themes and their bad news breaking practises. This is because the sub themes present the themes in a step-by-step or process-oriented manner. The establishment of the sub themes begin with the five core themes, after which they investigate common sub themes based on the previous breaking bad news models.

The respondents do prepare themselves for the breaking bad news session. This is done by majority of them having both Item 1 (Get informed of the patient's medical conditions before breaking bad news) and Item 2 (Prepare a private/comfortable place to break bad news) in

their practices. Before imparting bad news to a patient, 97.4 percent of responders made sure to educate themselves on the patient's medical condition. It is because they are the authority figures of the news (VanKeer et al., 2019) who are in-charge of not just bearing the news but also managing the whole session. It is very important for them to have all of the necessary information and understanding about what is going on. This demonstrates that they are concerned and care for the patients as well as the recipients of the news. Being informed of the necessary details about the patients not just showing that the bearers hold responsibility towards the patient's case as a healthcare practitioner (Vaidya et al., 1999), it also will potentially affect the quality of delivery of bad news (Paramasivan & Khoo, 2020). If they lack information of the case, they might fail at filling in the recipients with the information needed about the patients, distorting the whole function of the breaking bad news session.

The preferences of healthcare providers for breaking bad news may similarly reflect the preferences of recipients when receiving bad news. Because the bearers of the news are considerate of the preferences of the recipients, they adjust their delivery manner to meet those preferences. Almaiman et al (2021) found that the majority of caretakers of children with chronic kidney illness preferred to receive bad news when they were alone with the bearers of the news (58.2 percent). This demonstrates that people value a private setting in which to receive bad news. Another study, Seifart et al (2014), also mentioned that undisturbed surroundings was one of the most important requests made by the majority of the respondents (86.9%), which later determined their satisfaction with overall bad news delivery. With this in mind, the respondents (80.3 percent, or the vast majority) have expressed a desire to meet with the recipients in private.

Item 3 (Assess the recipients' knowledge and perception of the patient's medical condition) and Item 4 (Find out what and how much the recipients want to know) deal with respondents exploring the recipients' state of knowledge before delivering the news. The plurality of them includes these two items in their breaking bad news routines. Physicians must gather necessary information from recipients to determine the patient's level of understanding and expectations of the patient's medical conditions. This helps them know where and how to start this. This explains why about 95% of the respondents prefer to have this item when delivering bad news. According to Hashim (2017), it is critical to inquire about the patient's prior knowledge of the illness. This is true not only for patients, but also for those who receive the news, such as caregivers or families. Exploring their knowledge and comprehension of the circumstance allows them to be more informed about what to expect.

84.2 percent of responders go to the effort of determining what the recipients want to know and how much they want to know. This aids them in deciphering the boundaries that the recipients wish to establish. This is because some recipients prefer not to know too much information, while others prefer to know more than is required. It is the responsibility of the news bearers to find this out so that they can predict what the recipients would like to know and to what extent they want to know it. Clayton et al (2008, pg. 657) highlighted that in order "to offer information to patients, ascertain how much information they want, respect that preference and re-negotiate this at multiple time-points, rather than considering this a one-off communication episode". Some people choose to take an active position in the bad news session, while others prefer to take a quiet role. According to Elkin et al (2007), more than half of the patients in their study (52%) preferred a passive involvement in the decision-

making process. They will just allow physicians to recommend what they believe is best for the patients. Seifart et al (2014) found that a large proportion of patients preferred a passive role as well. This emphasises the importance of tailoring information and decision-making to the requirements of the recipients of the news. The question is how doctors would go about doing so. Hashim (2017); Back et al (2005) then suggest using the "ask-tell-ask" strategy, which can be beneficial to healthcare professionals. This method involves asking, telling, and asking again in a loop, with little bits of information to avoid overwhelming the recipients and simultaneously, assisting the bearers of the news in appropriately strategizing their plans. This also offers the recipients of the news the autonomy to choose whether to be actively involved in the process or not. Newall et al (1987) also emphasised that the danger of providing lack of information of the news may cause the recipients to be depressed and uncertain and cause them anxiety. This demonstrates the need of providing clear and sufficient information to recipients, but, once again, it also depends on what the recipients consider sufficient. Seifart et al (2014, pg. 710) also suggested an extended version of "ask-tell-ask" strategy in which it makes more sense with the patient-centred approach. They proposed "ask–tell–invite" and later changed it to "ask–reassure-understanding". This strategy cares not just about the telling of the news, but also the before and after it is told. The researchers however argue that all three strategies are useful for breaking bad news depending on the stage of breaking bad news. For example, physicians at the announcement of the news stage and physicians at the management of the news stage may utilise different strategies or might have their own strategies. These strategies however are critical in providing practitioners with ideas for how to approach the task. The researchers believe that both items 3 and 4 are often combined. Once the recipients are asked about what they already know and their understanding of the situation, they then will be given power over the rate and amount of information they get, as underlined by (Miller et al., 1999).

The next theme is where the announcement of the bad news happens. In this theme, the respondents make sure to provide hints before disclosing the bad news (Item 5) and use appropriate language or 'layman' language to break bad news (Item 6). More than 70% of respondents believe that giving recipients cues is necessary before delivering the news. According to Lind et al (1989), a prominent source of complaint is the absence of warnings given before exposing the information. The recipients are taken aback and unprepared, which contributes to their hurt and denial. According to Shaw et al (2012), this practice has resulted in certain types of disorientation on the side of the recipients, as well as animosity toward the physician. Giving cues or hints before delivering the news assists recipients in being better prepared to receive it. If they are prepared, they will be more accepting of the news, which will aid in their understanding and call for the right reaction to the news.

A recent study by Almaiman et al (2021) shows 86.3 percent of those who received bad news preferred it to be delivered in a simplified scientific manner, which corresponds to almost all respondents' (98.7%) preference for using appropriate language or 'layman' language when breaking bad news. This is parallel to a previous study done by Randall and Wearn (2005) that the respondents insist for the bad news communication to be done clearly. According to the respondents, bad news transmission is only effective when the recipients of the news understand the content of the news being sent to them. Simple and appropriate language is very helpful in aiding comprehension. As asserted by Fallowfield and Jenkins (2004), poorly conveyed unpleasant news can lead to confusion, long-term grief, and resentment; while,

skilfully communicated bad news can aid understanding, acceptance, and adjustment. Future actions or decisions relating to the news can be taken quickly and effectively after they comprehend the content of the news.

The management of bad news takes place in the following theme, attending to the recipients' reactions to the news. This is the stage in which the respondents allow the recipients to express their feelings and emotions after receiving the news (Item 7) while also offering support and understanding (Item 8). As asserted by Ptacek and Eberhardt, (1996), recognising and exploring the recipients' emotional states and dealing with their emotions are skills that all clinicians should possess. Giving the recipients of the news the opportunity to express their thoughts of the news is found to aid in the formation of a good relationship and later help the healthcare professionals to manage the situation better. This may be what 88.2 percent of respondents feel since they prefer to include this item in their bad news breaking course. As suggested by Bain et al (2014), the recipients should be provided ample time to vent their feelings after receiving the bad news. This is because, "unexpressed emotions may impede the patient's trust and confidence in medical care" (Hashim, 2017, pg. 31). Breaking bad news goes beyond the telling of bad news, it includes the management of the situation after the news is delivered (Miller et al., 1999). Breaking bad news needs cooperation from the recipients for it to be successful in which it helps the healthcare professionals to express necessary feelings of empathy, share making decisions together, and sometimes, find alternative options.

Many respondents believe that showing support and understanding to recipients after they have gotten bad news is vital, with almost all of them preferring to do so in their practises. Ptacek and Ptacek (2001) demonstrate this by stating that special care should be paid to creating a comfortable setting, spending ample time with the patient, and seeking to empathise with the patient's experiences. Buckman (1992) believes that to achieve the goal of communicating bad news, demonstrating empathy is essential as a way of showing support and understanding to those who have received bad news. Patients in a study done Randall and Wearn (2005) also mentioned their preference of having physicians to display empathy when breaking bad news. Buckman later adds that the doctor must be open to the client's possible emotional reactions and respond empathetically to them immediately after giving the bad news. These two items are proven to be interconnected, with the presence of one item necessitating the presence of the other. Another study also shows that their respondents want two major things out of breaking bad news sessions: (1) "the information" and (2) "emotional supportiveness from their physicians" (Sastre et al., 2011, pg 653)

The final theme is summarising the session, which requires respondents to have both Item 9 (Summarize the session) and Item 10 (Explain future intentions about the patient's circumstances) in their practises. It is the duty of healthcare practitioners to summarise the session before calling it off, as 80.3 percent of the respondents do. This step is necessary since it allows you to assess the recipients' understanding of the news and situation. Simultaneously, this session may be used to check for any gaps in the dialogue that the news bearer or the news recipient may notice (Abdul Hafidz & Zainudin, 2016). The session should be summarised in a courteous manner. The recipients' concerns raised throughout the session should be emphasised and summarised as it is the most important aspect of bad news transaction for the recipients (Narayanan et al., 2010). It is also critical to note that recipients

who are shocked or irritated will retain less information, so healthcare providers should be prepared to repeat any key points. Therefore, written documents should be given wherever feasible (Narayanan et al., 2010). This step also encourages the bearers of the bad news to continue to assist the recipients if they have any further questions, such as offering to assist in informing others (e.g., other family members) about the bad news and directing them to places where they can get more information or seek assistance (e.g., support groups). According to Baile et al (2000), these offers might create the impression that the physician values the recipients' wants, which will assist feed their happiness to the overall breaking bad news session.

The findings suggest that the respondents prefer to discuss future plans for the patient's condition (86.8% of them) because they feel obligated to inform the recipients of what will happen after the news has been dropped. They are aware that bad news has altered the future of those who have received bad news in a negative way, and that future plans, although not solving the problem or improving the situation, will help to alleviate the situation. Although the patient's state is unlikely to be positive, future plans offered by caregivers who received terrible news in Almaiman et al (2021, pg 89) should exhibit a hopeful perspective. Hope is critical to a person's well-being and quality of life (Rustoen, 1995). To help the recipients accept the news and move on from the circumstance, a positive light is appreciated during the session. As much as wanting to give hopes to the recipients, as argued by Clayton et al (2008), it is important for healthcare professionals to have balance between that and being honest. Being realistic with the situation is needed and the healthcare professionals need to make sure recipients are aware of it.

In general, it can be said that the different backgrounds of the news recipients place additional expectations on healthcare practitioners to change the manner they convey bad news accordingly, which may have an impact on their ability to deliver bad news effectively. Specifically, tailor their delivery towards the needs of the recipients of the news necessitates a more engaged, shared, and negotiated breaking news transaction, in which the patient can exchange information with news bearers and actively participates in decision-making. All health systems strive to achieve maximum patient satisfaction, as Al-Mohaimeed and Sharaf (2013); Alrashdi (2012) pointed out, and evidence has demonstrated that a patient-centred approach has resulted in increased patient satisfaction. It is an approach that prioritises clients' needs while also taking clinical evidence into account. As Clayton et al (2008) said in their studies, the recipients of the news stressed that the manner in which bad news is conveyed to them is frequently as significant as, if not more important than, the bad news itself. A patient-centered communication of breaking bad news gave the best satisfaction score (M= 2.96) compared to disease-centred (M= 1.74) or emotion-centred (M= 1.73) communication style. This proves how recipients prefer "the physician was perceived as most emotional, least dominant, most appropriate in his ability to convey information, most available and most expressive of hope" (Mast et al., 2005, pg. 249) when breaking bad news. The physician should frequently inquire about the patient's comprehension and welcome questions from the recipients. Making decisions after receiving bad news is never easy, especially if the recipients are too shocked by the news and have a hard time to process or register the received information.

Conclusion

This study concludes that the respondents' preferences for imparting bad news are similar to the SPIKES model, which is the most well-known and widely employed by healthcare practitioners. This is because they unconsciously put the model's suggested steps into practice because they already have preconceived notions about how bad news should be delivered. This study proposes five themes of breaking bad news, each of which has ten sub-themes that are comparable to the SPIKES model in that all of the items agree with those presented in SPIKES. Based on prior studies, these preferences also mirror the demands of clients who are the recipients of the news. This study indicates a client-centred approach to delivering bad news, in which those who deliver bad news must be adaptive in their delivery, taking into account the clients' preferences and needs. Taking all of this into account, the study urges healthcare stakeholders to take serious steps to implement a guided communication process that is more tailored to the preferences of clients, as breaking bad news is a complex process that will have a significant and long-term impact on the recipients' perceptions of overall healthcare quality.

Ethical Approval

The Ministry of Health Malaysia granted ethical approval for this study (RSCH ID-21-01383-66W) and informed consents were collected from respondents before the questionnaires were distributed.

Disclosure Statement

In the course of performing the study and producing this article, no conflicts of interest have been declared by the authors.

References

Abdul Hafidz, M. I., & Zainudin, L. D. (2016). Breaking bad news: An essential skill for doctors. *Medical Journal of Malaysia*.

Al-Mohaimeed, A. A., & Sharaf, F. K. (2013). Breaking bad news issues: A survey among physicians. *Oman Medical Journal*. https://doi.org/10.5001/omj.2013.05

Almaiman, W., Alfattani, A., & Alshareef, T. A. (2021). Breaking bad news to children with chronic kidney disease: A questionnaire-based study and literature review. *International Journal of Pediatrics and Adolescent Medicine*, *8*(2), 87–93. https://doi.org/10.1016/j.ijpam.2020.03.002

Alrashdi, I. (2012). Evaluation of quality of healthcare: to what extent can we rely on patient expectations and preferences. *Oman Med J*, *27*(6), 448–449.

Back, A., Arnold, R., Baile, W., Tulsky, J., & Fryer-Edwards, K. (2005). Approaching difficult communication tasks in oncology. *CA Cancer J Clin*, *55*(3), 164–177.

Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., & Kudelka, A. P. (2000). SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer. *The Oncologist*, *5*(4), 302–311. https://doi.org/10.1634/theoncologist.5-4-302

Bain, M. G., Lian, C. W., & Thon, C. C. (2014). Breaking bad news of cancer diagnosis-Perception of the cancer patients in a rural community in Malaysia. *South Asian Journal of Cancer*, *3*(2), 116–121. https://doi.org/10.4103/2278-330X.130447

Buckman, R. A. (1992). How to Break Bad News: A Guide for Health Care Professionals. John Hopkins University Press.

Buckman, R. (1984). For Debate. British Medical Journal, 288(6430), 1597–1599. https://doi.org/10.1136%2Fbmj.288.6430.1597

Clayton, J. M., Hancock, K., Parker, S., Butow, P. N., Walder, S., Carrick, S., Currow, D., Ghersi, D., Glare, P., Hagerty, R., Olver, I. N., & Tattersall, M. H. N. (2008). Sustaining hope when communicating with terminally ill patients and their families: a systematic review. *Psycho-Oncology*, *17*(7), 641–659. https://doi.org/https://doi.org/10.1002/pon.1288

Dale MacLaine, T., Lowe, N., & Dale, J. (2021). The use of simulation in medical student education on the topic of breaking bad news: A systematic review. *Patient Education and Counseling*, *104*(11), 2670–2681. https://doi.org/10.1016/j.pec.2021.04.00

Elkin, E. B., Kim, S. H. M., Casper, E. S., Kissane, D. W., & Schrag, D. (2007). Desire for information and involvement in treatment decisions: Elderly cancer patients' preferences and their physicians' perceptions. Journal of Clinical Oncology, 25(33), 5275–5280. https://doi.org/10.1200/JCO.2007.11.1922

Fallowfield, L., & Jenkins, V. (2004). Communicating sad, bad, and difficult news in medicine. In *Lancet*. https://doi.org/10.1016/S0140-6736(03)15392-5

Girgis, A., & Sanson-Fisher, R. W. (1995). Breaking bad news: Consensus guidelines for medical practitioners. *Journal of Clinical Oncology*. https://doi.org/10.1200/JCO.1995.13.9.2449

Hashim, M. J. (2017). Patient-Centered Communication: Basic Skills. *American Family Physician*, *95*(1), 29–34.

Igier, V., Munoz Sastre, M. T., Sorum, P. C., & Mullet, E. (2015). A Mapping of People's Positions Regarding the Breaking of Bad News to Patients. Health Communication, 30(7), 694–701. https://doi.org/10.1080/10410236.2014.898013

Kaur, P., Stoltzfus, J., & Yellapu, V. (2018). Descriptive statistics. International Journal of Academic Medicine, 4(1), 60–63. https://doi.org/10.4103/IJAM.IJAM

Lind, S. E., DelVecchio Good, M. J., Seidel, S., Csordas, T., & Good, B. J. (1989). Telling the diagnosis of cancer. Journal of Clinical Oncology. https://doi.org/10.1200/JCO.1989.7.5.583

Mast, M. S., Kindlimann, A., & Langewitz, W. (2005). Recipients' perspective on breaking bad news: How you put it really makes a difference. *Patient Education and Counseling*, *58*(3 SPEC. ISS.), 244–251. https://doi.org/10.1016/j.pec.2005.05.005

Mazalan, M. I., Bogal, N., Arham, A. F., Abdullah, M. S., Hanapiyah, Z. M., Norizan, N. S., & Jamil, M. F. (2021). Students' Perception towards E-Learning: A Descriptive Analysis at Uitm Kampus Bandaraya Melaka. *International Journal of Academic Research in Business and Social Sciences*, *11*(9), 638–648.

Mengin, A. C., Kayser, C., Tuzin, N., Perruisseau-Carrier, J., Charpiot, A., Berna, F., Lilot, M., & Vidailhet, P. (2021). Mindfulness Improves Otolaryngology Residents' Performance in a Simulated Bad-News Consultation: A Pilot Study. *Journal of Surgical Education*, *78*(4), 1357–1365. https://doi.org/10.1016/j.jsurg.2020.11.009

Miller, S. J., Hope, T., & Talbot, D. C. (1999). The Development of a Structured Rating Schedule (the BAS) to Assess Skills in Breaking bad news. *British Journal of Cancer*, *80*(5/6), 792–800.

Sharif, M. N., & Ibrahim, N. A. (2021). Communicating Bad News in Health Context: A Review of Key Models Used by Healthcare Providers. In N. B. Haladin, W. F. W. L. Wan Fakhrudin, Y. Yi, E. Voon Suk Hsien, A. N. Zafrulshamirza, N. S. Abd Wahid, M. R. Othman, & F. Abu Bakar (Eds.), *Virtual Language and Communication Postgraduate International Seminar 2021 Proceedings* (pp. 28–34). Language Academy, Faculty of Social Sciences and Humanities, Universiti Teknologi Malaysia.

Narayanan, V., Bista, B., & Koshy, C. (2010). BREAKS protocol for breaking bad news. In *Indian Journal of Palliative Care*. https://doi.org/10.4103/0973-1075.68401

Newall, D. J., Gadd, E. M., & Priestman, T. J. (1987). Presentation of information to cancer patients: A comparison of two centres in the UK and USA. *British Journal of Medical Psychology*, *60*(2), 127–131. https://doi.org/10.1111/j.2044-8341.1987.tb02722.x

Oikonomidou, D., Anagnostopoulos, F., Dimitrakaki, C., Ploumpidis, D., Stylianidis, S., & Tountas, Y. (2017). Doctors' Perceptions and Practices of Breaking Bad News: A Qualitative Study From Greece. Health Communication, 32(6), 657–666. https://doi.org/10.1080/10410236.2016.1167991

Paramasivan, A., & Khoo, D. (2020). Standardized Patients Versus Peer Role Play—Exploring the Experience, Efficacy, and Cost-Effectiveness in Residency Training Module for Breaking Bad News. Journal of Surgical Education, 77(2), 479–484. https://doi.org/10.1016/j.jsurg.2019.10.009

Ptacek, J. T., & Eberhardt, T. L. (1996). Breaking bad news: A review of the literature. In *Journal of the American Medical Association*. https://doi.org/10.1001/jama.276.6.496

Ptacek, J. T., & Ptacek, J. J. (2001). Patients' perceptions of receiving bad news about cancer. *Journal of Clinical Oncology*, *19*(21), 4160–4164. https://doi.org/10.1200/JCO.2001.19.21.4160

Rabow, M. W., & McPhee, S. J. (1999). Beyond breaking bad news: How to help patients who suffer. *Western Journal of Medicine*.

Royal College of Physicians. (1997). Improving communication between doctors and patients. Summary and recommendations of a report of a working party of The Royal College of Physicians. *J R Coll Physicians Lond*, *31*(3), 258–259.

Randall, T. C., & Wearn, A. M. (2005). Receiving bad news: Patients with haematological cancer reflect upon their experience. *Palliative Medicine*, *19*(8), 594–601. https://doi.org/10.1191/0269216305pm1080oa

Rosenbaum, M. E., Ferguson, K. J., & Lobas, J. G. (2004). Teaching Medical Students and Residents Skills for Delivering Bad News: A Review of Strategies. In *Academic Medicine*. https://doi.org/10.1097/00001888-200402000-00002

Rustoen, T. (1995). Hope and quality of life, two central issues for cancer patients: a theoretical analysis. *Cancer Nursing*, *18*(5), :355–361.

Sastre, M., Teresa, M., Sorum, P. C., & Mullet, E. (2011). Breaking Bad News: The Patient's Viewpoint. Health Communication, 26(7), 649–655. https://doi.org/10.1080/10410236.2011.561919

Seifart, C., Hofmann, M., Bär, T., Riera Knorrenschild, J., Seifart, U., & Rief, W. (2014). Breaking bad news-what patients want and what they get: Evaluating the SPIKES protocol in Germany. *Annals of Oncology*, *25*(3), 707–711. https://doi.org/10.1093/annonc/mdt582

Shaw, J., Brown, R., & Dunn, S. (2015). The impact of delivery style on doctors' experience of stress during simulated bad news consultations. *Patient Education and Counseling*. https://doi.org/10.1016/j.pec.2015.08.023

Vaidya, V. U., Greenberg, L. W., Patel, K. M., Strauss, L. H., & Pollack, M. M. (1999). Teaching Physicians How to Break Bad News. *Archives of Pediatrics & Adolescent Medicine*, *153*(4), 419–422. https://doi.org/10.1001/archpedi.153.4.419

Van Keer, R. L., Deschepper, R., Huyghens, L., & Bilsen, J. (2019). Challenges in delivering bad news in a multi-ethnic intensive care unit: An ethnographic study. *Patient Education and Counseling*, *102*(12), 2199–2207. https://doi.org/10.1016/j.pec.2019.06.017

Appendices
Appendix A

SPIKES Model

Step	Descriptions
Step 1 - Setting up for the breaking bad news	● Do a mental rehearsal. ○ Review the case and brace for recipients' emotional responses or tough questions ● Choose a private setting. ● Include family members of patients. ○ Should be of patient's choice and not too many; one or two members is ideal ● Sit down. ○ This informs recipients that the discussion will not be in a rush ● Make connection with the recipients. ○ Consider appropriate body language. ● Manage interruptions. ○ Inform the patient about any time restrictions you might have or any interruptions you may experience.
Step 2 – Assessing the recipients' Perception	● Identify the recipients' state of awareness of the medical status of the patient. ○ This can help to correct any misinformation. ● Recognise any denial of disease by the recipients. ● Adapt the bad news delivery to what recipients understand.
Step 3 – Obtaining the recipients' Invitation	● Make sure the recipients invite providers into disclosing the news. ○ They should specifically demonstrate a desire for the information. ○ If they do not want to know the specifics, offer to address any concerns they might have in the future
Step 4 – Giving Knowledge and Information to the recipients	● Warning the recipients that bad news is coming ● Break bad news, following the suggestions: 1. start at the recipients' level of understanding and vocabulary. 2. try using nontechnical words 3. avoid unreasonable bluntness 4. give information in small chunks a. constantly check the recipients' understanding. 5. Do not say that there is nothing you can do for the patient anymore.
Step 5 – Addressing the recipients' Emotions with empathic responses	● Give support and solidarity to the recipients with empathic responses. ○ 4 steps to provide empathic responses: 1. Note any emotion on the part of the recipients. 2. Classify the emotion encountered by the recipients 3. Recognize the cause behind the emotion.

	4. Allow the recipients some time to share their feelings- let them realise that you have linked the emotion with the cause for the emotion. ○ The powerful way of providing support is by combining empathic, exploratory, and validating statements
Step 6 – Strategy and Summary	● Summarise the meeting ● Discuss future plans.

Appendix B

The presence and absence of breaking bad news sub-themes

Theme	Sub-theme	SPIKES Models	Kaye's 10 Step	ABCDE	BREAKS
Theme 1: Prepare for the breaking bad news session	Sub-theme 1: Get informed of the patient's medical conditions before breaking bad news	+ Review the case and brace for recipients' emotional responses or tough questions	+ Know all the facts	+ Review relevant clinical information.	+/- prepare answers for the anticipated questions from the recipients
	Sub-theme 2: Prepare a private/comfortable place to break bad news	+ Choose a private setting	+ Ensure privacy	+ Arrange for adequate time, privacy and no interruptions	+ have a proper physical set up
Theme 2: Explore the recipients' state of knowledge	Sub-theme 3: Assess the recipients' knowledge and perception of the patient's medical condition	+ Identify the recipients' state of awareness of the medical status of the patient	+ Start with open-ended questions (e.g., "How did it all start?")	+ Ask what the patient or family already knows.	+ explore the recipients' state of knowledge
	Sub-theme 4: Find out what and how much	+ Adapt the bad news delivery to what	+ Do not force information onto the patient (e.g.,	+ Determine what and how much the patient	-

	the recipients want to know	recipients understand	"Would you like me to explain a bit more?") & Allow the patient to control the amount of information he (she) receives	wants to know.	
Theme 3: Communicate the bad news	Sub-theme 5: Provide hints before disclosing the bad news	+ Warning the recipients that bad news is coming	+ Not straight out with it! (i.e., "I'm afraid it looks rather serious")	+ Warn the patient that bad news is coming.	provide warning shots
	Sub-theme 6: Using appropriate language/'layman' language to break bad news	+ start at the recipients' level of understanding and vocabulary & try using nontechnical words	+/- Details might not be remembered, but the way you explain them will be	+ Be frank but compassionate; avoid euphemisms and medical jargon.	+ Announcement must be straightforward, avoid medical jargon completely, short (three pieces of information at one time) and easy to understand.
Theme 4: Attend to the recipients' reactions to the news	Sub-theme 7: Allow recipients to express their feelings and emotions after receiving the news	+ Allow the recipients some time to share their feelings- let them realise that you have linked the emotion with the cause for the emotion	+ Ask "What are your concerns at the moment?"	+ Allow for silence and tears; proceed at the patient's pace.	+ Provide sufficient space for emotions
	Sub-theme 8:	+ The powerful way of	+	+ Assess and respond to	+ attend the recipients'

	Show support and understanding to the recipients (e.g.: empathetic remarks)	providing support is by combining empathic, exploratory, and validating statements	Acknowledge the feelings	the patient and the family's emotional reaction; repeat at each visit.	emotional breakdown
Theme 5: Summarise the session	Sub-theme 9: Summarise the session	+ Summarise the meeting	+ Review concerns, plans for treatment	+ Conclude each visit with a summary and follow-up plan.	+ summarise the session and attend to the concerns expressed by recipients treatments/care plans
	Sub-theme 9: Explain future plans regarding the patient's conditions	+ Discuss future plans	+ Offer further information	+ Offer realistic hope according to the patient's goals.	+ Highlights the focal points and future

Appendix C

Survey on Communicating Bad News among Healthcare Professionals

This survey aims to identify the breaking bad news experience and practices among healthcare professionals at the government Malaysian hospitals. Please answer the following questions as honestly as possible. All responses will be kept confidential and used for academic purposes only.

Section A: Background Information

(Tick your answer)

1. Gender

Male	
Female	

2. Years of working with the hospital/healthcare industry

0 to 5 years	
5 to 10 years	
More than 10 years	

3. Medical discipline.
   You can tick more than one answer.

Specialist	
Medical Officer	
Postgraduate Student	
Nurse	
Others	

If others, please specify. _____

Section B: Preferences of Delivering Bad News to Patients or Families

1. How do you deliver bad news?

No	Item	Face-to-face		
		Yes	No	Sometimes
Prepare for the breaking bad news session				
1	● Study the patient's medical conditions before breaking bad news			
2	● Prepare a private/comfortable place to break bad news			
Explore the recipients' state of knowledge				
3	● Assess the recipients' knowledge and perception of the patient's medical condition			
4	● Find out what and how much the recipients want to know			
Communicate the bad news				
5	● Provide hints before disclosing the bad news			
6	● Using appropriate language/'layman' language to break bad news			

Attend to the recipients' reactions to the news				
7	● Allow recipients to express their feelings and emotions after receiving the news			
8	● Show support and understanding to the recipients (e.g.: empathetic remarks)			
Summarise the session				
9	● Summarise the session			
10	● Explain future plans regarding the patient's conditions			

*****Thank you for your full cooperation*****