

Methods of Hearing Bad News: Experiences of Patient and the Family: A Qualitative Study

Mohammad Jalali¹, Ahmad Nasiri² and Heydar Ali Abedi^{3*}

- 1- M.A. in Education of Nursing, Islamic Azad University, Branch of Khorasgan, Isfahan. Supervisor of Shahid Rajaei Hospital, Birjand
- 2- Assistant Professor, Center of Qualitative Studies in Health Domain, Birjand University of Medical Sciences
- 3- Assistant Professor, Islamic Azad University, Branch of Khorasgan, Isfahan, Department of Nursing and Parturition

Corresponding author: Heydar Ali Abedi

ABSTRACT:

Introduction: Giving bad news to the patients is the main issue of health cares. Since informing the bad events to the patients and their families is the principle rights of patients, so considering the experiences of the patients and their families toward the methods of receiving bad news can prevent the more damages to the patients and their families. Therefore, the present paper tries to describe the experiences of the patients and tier families toward this issue by the medical staff. **Method:** This study as a qualitative paper was done by the phenomenological methods. The samples were chosen among the people who had experienced the information of bad news in Birjand during 2013. The sampling was based on a target and continued to the information saturation as the number of participants equaled 10 individuals. The note taking was used in order to fulfill the process of data collection. The method of Colaizzi was used for data analysis and the rigidity of this study is based on the criterion of accuracy. **Findings:** The examinees were in the age range of 25 – 70. Based on this method, at the first stage, 120 codes were obtained as they are the compiled concepts. In this stage, a list was provided from the extracted codes. Then, the different thematic groups with similar meanings were placed into two large thematic groups such as receiving the bad news explicitly and receiving the bad news implicitly. **Conclusions:** By considering that the patients and their family receive the bad news by using the different method by the medical staff, the results were shown that the medical staff must use the indirect methods in order to inform the patients and their families toward bad news as they prevent the damage of this group of people and also they must learn the accurate education in this field.

Keywords: Bad news, Patient, Family, Medical Staff.

INTRODUCTION

Bad news is the main part of health and medical cares and refers to the news which has bad consequences on the future of people (1). In some cases, this word / term is being used in order to determine a serious and danger diseases or the possible death (2). But, bad news is not only summarized in the current events and the undesirable conditions, but also refers to hearing a subject which is not desirable (3). Based on the charter of the rights of the patients and the principles of medical ethics, the patients and their families have the right to receive the news about their disease and their health (4). How to transfer the bad news by the medical staff is one the most important part of presented subjects in the field of medicine. There is a different between the patients and their families about how to say the real point. In a study done on the cancer patients, 83% of them preferred to hear the fact but 45% of their families rejected it (5). Bato, (2006) in their studies came to the results as 57% of the patients preferred the presence of their families for hearing bad news about their disease (6). Although the current situation of giving bad news in the care and health systems of Islamic countries is not known (7), the dominant method in most countries was making

clear the incurable disease to the patients and their families and in other words, it can be said that the benefits of transferring information and telling the fact to the patients and their families is preferred to hidden it (1). By considering that several studies were done about the methods of giving bad news to the families by the medical staff and also there are main challenges in informing the patients and their families toward the diseases, it is hoped that by studying the experiences of patients and their families to the methods of receiving bad news, these challenges were solved and also affect the methods of practical and scientific informing to the patients and their families.

MATERIALS AND METHODS

Methods

The qualitative study allows you to introduce the subjects based on the view of participants and understand the meanings and interpretations which were presented by them. This understanding reflects the interpretative approach for example this method is sued for understanding the experiences of people about a disease by introducing the cultural and social norms (8). One of the approaches of qualitative studies is phenomenology (9). When the considered phenomenon includes several criterions, this method is useful (10). This study was done for explaining the experiences of the patients and their families to the methods of receiving bad news by the medical staff by using the qualitative method and the approach of phenomenology. First, the participants were selected by considering the aim of this study which is the description of the experiences of patients and their families to the dangerous diseases or the families faced the dead of their embryo, infant or child and the others who referred to the hospitals of Birjand among the available society. The information collection was done by the in-depth interview. The open and non-structured interviews were done for 60 – 90 minutes. Each interview was started by a general question: express your experiences about hearing bad news such as your disease or the death of one your family member? And then by the continuance of interview, the main and especial questions based on the results of the first interviews and the main classes in order to fulfill the aims of this study were asked. The criterion for ending the sampling was data saturation means the repeatedability of data and lack of access to the new data (11).

In this study, the sampling information was continued until the saturation stage as well, the sample volume equaled 10 participants and for this reason, collecting more information was not necessary. After completing interview, the recorded tape was checked by the researcher and then, the interviews were written on the papers. After that, coding and analysis of information were done. After classification of codes and the integration of related codes, the formulized concepts were arranged within the thematic especial groups and at the end; all grouped concepts in terms of the aim of this study were classified. In this paper, for recording and analyzing data, the analysis method of Colaizzi in seven stages was used. In order to confirm the rigidity and accuracy of data, the criterion of accuracy was used. Validity, trust, reliability and fitness are the main criterion of scientific accuracy in the qualitative studies (12). Validity means that the points resulted from the real experience of an individual must be acceptable. In this relation, it can be pointed out the long term involvement of researcher with data, the review of supervisors and checking the findings with the participants. Reliability in these kinds of studies means that these studies must be controllable; if a researcher does this study again, the same results must be obtained. Validity shows that each study must be without bias as well, the information must be vivid and clear and the texts of interviews and codes must be read by some of the scientific board and they must present their viewpoints. Transferable or fitness means that it is likely to transfer the findings of these studies to the other in similar situations. In this paper, all ethical points were observed such as receiving the permit of ethical committee, receiving the conscious testimonial/confirmation, explaining the aim of this study, keeping the anonymity of participants, considering the lapse of participants in each stage of the study and observing their psychological and physical welfare.

RESULTS AND DISCUSSION

In this study, about 10 participants in the age range of 25 – 70, by considering the aim of this paper (such as describing the experiences of the patients and their families toward the dangerous diseases or the families faced the dead of their embryo, infant or child and the others who referred to the hospitals of Birjand and heard the bad news in the recent times) were selected among the available society. And the results were obtained based on this concept: methods of receiving bad news including receiving the bad news implicitly and explicitly. The results were shown that the medical staff informed the bad news to the patients and their families by using the different methods.

Receiving the bad news explicitly; some participants refers to the way of telling bad news to them directly. Based on the view of participant number 5: The medical staff (in a direct way) said me your child has cancer. For this reason, that participant complained this way of informing by this member. According to the participant number 4, when the doctor examined my child, he said your child has heart problem and he must be operated. Based on participant

number 1, when we doubted the disease of my father, we wanted his doctor to tell us what his problem is, explicitly. Based on these sayings, since most of these patients and their families prefer to know something about the diseases, explicitly, but some of them do not prefer this explicit way.

Receiving the bad news implicitly; some participants refers to the way of telling bad news to them indirectly. Based on the saying of participant number 2; when the medical staff tried to initiate and begin the especial treatments and examinations, I found my disease. According to the participant number 3, when the results of my father's tests were high, I found out his disease. Based on the idea of participant number 7, I found out my mother's disease in terms of the discussions of medical staff "115". Participant number 3 said: when the physicians said their final results, I have found out my problem. And also participant number 2 said: I heard the death of my child by my husband who heard it through the discussions of nurses.

Discussion and Conclusion

The analysis of data was shown that the patients and their families informed about their disease through different ways and also they have different ideas about this way of informing. Beckman (1996) said: if you give bad news to the patients and their families, they do not forgive you and if you give them this news indirectly, they do not forget you kindness (13). In the western societies, they believe this way means giving bad news directly but in the study in the Arabian countries, this issue is different in the Muslim countries (14). In the qualitative study by Al-Mohaimeed and Sharaf (2013) in Saudi Arabia, about 70% of participants believe that the medical staff must give the bad news first to their families and then to the patient as well, 90% of them prefer to give bad news (15). In the study of Cleary, (2010), most of patients (92%) want to know their disease as a legal and ethical right (16) and also in the study of Kumar, (2009), it was determined as most of patient affected by cancer expressed their interest toward knowing their disease, its prognosis and diagnosis (17). In the study of Sareshti, (2013), half of the searching units were opposed to the allocation of/giving bad news (18) but the study done in Egypt indicates the tendency of mothers to the rapid disclosure of information (19) and also the findings of the study done by Oskotko, (2005) indicates that the rapid disclosure of bad news leads into the less communication with the patient and this issue results into more stress and concerns among the assistants/supporters (20). In our study, most participants do not prefer to receive the information, quickly. But in general, the dominant view is that the bad news must be given to the patients. And the benefits of this task are;

- Keeping and reinforcing the trust between the patients and the physician,
- Preventing the injuries to the patients,
- Increasing the consent of patients and
- Decreasing the legal measures against the physicians (1).

In a study, it was shown that 87% of the patients are declared their agreement toward informing bad news associated with their families but 62% of them preferred that their families must be informed about bad news (21); however, this amount in the western countries is less for example, in Ireland: 44%, Australia: 53%, and Portugal: 61%, they preferred that giving bad news must be associated with the presence of their families (22). In the study done by Manaqeb, (2013), 56% of the patients want to know about their disease and the idea of 40% of them was against this notion. 91% of them want to know about their disease and access whole information about it such as what the reason/cause of their disease is. 74% of them believed that the cancerous patients must know about their disease as well, 36% of them believe that these kinds of patients must know about how long they have been alive however; the idea of 38% of them was against this view (21). It is clear that the differences of these statistics depend on the cultural and social situations of patients as well; these cultural and social differences are clear and tangible among the participants. Shaw, (2011) came to this result as there are three ways for giving bad news:

- Blunt: In this way, bad news is giving within the first 30 seconds;
- Forecasting: In this way, bad news is giving within 2 minutes and
- Styling: The delay in giving bad news is more than 2 minutes (23).

And in our study, most participants experienced bad news by time – delay.

Although they prefer to know information about their disease, they do not like to know it at the same time and simultaneously by the medical staff as one of the mothers said that I hated that physician who gave me the cause of my child's disease simultaneously without considering any issue. It seems that in the western countries, the patient – oriented guideline method is an acceptable substitute by the model of complete disclosure toward giving bad news (24). The study of Ahmad Salem, (2013) was shown that in giving bad news, we must consider the cultural fields, religious values and the needs of patients and also their families (7). Fuji Morri (2009) found that the staff must be in the place of patients who must receive the bad news and also understand the feelings of the patients and their families. Then try to give them bad news as they do not stop their hope to living (25). The results of various studies show that one of the most important members of treatment team who can play a significant role in giving bad news

is the nurses (26). Kalber (2009) said that the experienced and well – skilled nurses are able to transfer the bad news. On the other hand, the studies were shown that in some cases, most of the medical staff faces problems in giving bad news. In addition, most studies in the western countries and also Iran emphasized the education of medical staff about how to inform the patients and their families about bad news and also they (medical staff) must receive the required skills in this field (21). Mors (2011) said that the patients prefer the indirect ways instead of direct and formal ways. The patients find the clues and also the behavioral changes/reactions of their families which indicate their diseases (28). Understanding the meaning of news in various situations is different. Giving the explicit information without sympathy is the complaint of some parents who received the bad news about their child by the medical staff (29). Based on the above studies, it seems that there is not a consensus in the way of informing bad news in various countries and in the different countries, the patients use their especial methods in terms of cultural and social properties and also the available conditions. Based on the culture of Iran, giving bad news in the implicit ways is more acceptable and the explicit way is rejected.

Final Conclusions

Since giving bad news to the patients based on the rules of Islam and the legal rights of countries is one of the main rights of patients, so this task is being done by the various methods as the medical staff must know about the accurate methods for informing them (the patients and their families) in terms of their culture. In order to fulfill this aim, holding the educational courses for familiarizing the medical staff with the methods of giving news is suggested.

REFERENCES

- Abdelmuktader AM and Abd Elhamed KA. 2012. Egyptian mothers' preferences regarding how physicians break bad news about their child's disability: a structured verbal questionnaire. *BMC Med Ethics*; 13: 14.
- Agard A and Nilstun T. 2002. "(Ethics in everyday care. The dialogue is physician's most important tool)." *Lakartidningen* 99(19): 2171-2173.
- Ahmed S and Abdel-Fattah S. 2013. Breaking Bad News: Current Prospective and Practical Guideline for Muslim Countries. *J Canc Educ* . 28:790–794.
- Al-Abdi SY, Al-Ali EA, Daheer MH, Al-Saleh YM, Al-Qurashi KH and Al-Aamri MA. 2011. Saudi mothers' preferences about breaking bad news concerning newborns: a structured verbal questionnaire. *BMC Med Ethics*; 23: 12-15.
- Al-Mohaimeed AA and Sharaf FK. 2013. Breaking Bad News Issues: A Survey Among Physicians. *Oman Med J*; 28(1):20-25.
- Buckman R .1996. Talking to patients about cancer. *BMJ*. 313(7059):699–700
- Burns N and Grove SK. 2010. Understanding nursing research: Building an evidence-based practice, Elsevier Health Sciences.
- Butow PN and Kazemi JN. 1996. "When the diagnosis is cancer: patient communication experiences and preferences." *Cancer* 77(12): 2630-2637.
- Cleary M and Hunt GE. 2010. "Receiving difficult news. Views of patients in an inpatient setting." *Journal of psychosocial nursing and mental health services* 48(6): 40-48.
- Fujimori M and Akechi T. 2005. "Good communication with patients receiving bad news about cancer in Japan." *Psycho-Oncology* 14(12): 1043-1051.
- Gilbey P. 2010. Qualitative analysis of parents' experience with receiving the news of the detection of their child's hearing loss. *International Journal of Pediatric Otorhinolaryngology*, 2010-03-01, Volume 74, Issue 3, Pages 265-270.
- Gonçalves F, Marques A, Rocha S, Leitão P, Mesquita T and Moutinho S .2005. Breaking bad news: experiences and preferences of advanced cancer patients at a Portuguese oncology centre. *Palliat Med*19(7):526–531
- Hennink M, Hutter I & Bailey A. 2011. *Qualitative Research Methods*. London: Sage Publicatin Ltd.
- Kalber B. 2009. Breaking bad news – whose responsibility is it? *Eur J Cancer Care*;18(4): 330.
- Kazemi A. 2007. Medical environment, patient and bad news. *Journal of research center and development of medical education*. 4th year. Number 2. pp. 133 – 139.
- Kohan M, Borhani F, Abbas Zadeh A, Soltan Ahmadi ZH and Xajeh Poor M. 2012. The experiences of mothers have نارس infants in ICU of infants. *Journal of qualitative studies in the health sciences*. 1st year. Number 1. pp. 41 – 51.
- Kumar M, Goyal S and Singh K. 2009. Breaking bad news issues: a survey among radiation.
- Lalor JG, Devane D and Begley CM. 2007. Unexpected diagnosis of fetal abnormality: women's encounters with caregivers;34(1): 80-8.
- Manaqeb A, Hossein Poor M and Mehrabi F. 2013. Attitude of patients about how to inform bad news. *Iranian journal of medical history and ethics*. 6th year. Number 4. pp. 68 – 79.
- Morse JM, Konrad S, Pooler C and Mott R. 2011. "Patterns of Suffering: Emotional Responses While Waiting for Breast Biopsy Results".
- Mystakidou K, Tsilika E, Parpa E, Katsouda E and Vlahos L .2005. Patterns and barriers in information disclosure between health care professionals and relatives with cancer patients in Greek society. *Eur J Cancer Care (Engl)* 14(2):175–181
- Noone I and Crowe M. 2000. "Telling the truth about cancer: views of elderly patients and their relatives." *Irish medical journal* 93(4): 104. *Oncologists*. *Indian J Palliat Care*.15(1):61–6.

- Parsa M, Baqeri A and Larijani M. 2011. Telling bad news to the patients and its different aspects (review study). Journal of medical ethics and history. 4th year. Number 6. pp. 1 – 14.
- Rager KB. 2005. "Compassion stress and the qualitative researcher." Qualitative Health Research 15(3): 423-430.
- Randall TC and Wearn AM. 2005. "Receiving bad news: patients with haematological cancer reflect upon their experience." Palliative medicine 19(8): 594-601.
- Sareshti M and Izadi A. 2013. Studying the attitude of medical staff to the skill of giving bad news in the departments of parturition and infants. Iranian journal of medical history and ethics. 6th year. Number 4. pp. 57 – 67.
- Shaw J, Dunn S and Heinrich P. 2012 May. Managing the delivery of bad news: an in-depth analysis of doctors' delivery style. Patient Educ Couns; 87(2):186-92
- Skotko B and Bedia RC. 2005. Postnatal support for mothers of children with Down syndrome. Ment Retard; 43(3):196-212.
- Streubert. 2011. Qualitative research in nursing: Advancing the humanistic imperative, Wolters Kluwer health.