Breaking Bad News During COVID-19 Time in Surgical, Emergency and Medical Specialties - What More we Need to Develop?

Hasan Khalaf¹, Basim Almothafar², Noor Alhalabi³

ABSTRACT
Background: Breaking bad news is one of the complex communication skills essential to the practice of every clinician. It involves not only the mere provision of information, but also how to deal with the emotions of the patients and the response of their relatives. Therefore, certain protocols are employed for this process, including “BREAKS”, “SPIKES”, and “ABCDE” protocols. The emergence of the COVID-19 pandemic mandated the use of strict infection control measures including social distancing, requiring the utilization of telecommunication technologies for breaking bad news. Objective: The aim of the study was to assess the use on non-physical methods in breaking bad news by physicians and to evaluate the need for more development and training. Methods: Cross-sectional survey conducted in Kufa Medical College Al-Najaf during April - June 2021, and included 60 physicians of various specialties working in that hospital. Results: Majority of participants 88.3% reported breaking bad news regularly. Less than half of participants 46.7% received training on breaking bad news, and only 13.3% received training on non-physical breaking bad news. More than half of participants mentioned that showing empathy is the area that needs improvement the most. Conclusion: High proportion of physicians lacks the necessary skills to break bad news, especially using non-physical ways during the pandemic. Well-structured programs are needed for the training of healthcare providers on breaking bad news, with certain adaptations for traditional protocols to be appropriate for telephone or video conferencing.

Keywords: breaking bad news, communication, COVID-19.

1. BACKGROUND

Breaking bad news is one of the complex communication skills essential to the practice of every clinician. Bad news refers to “any information that results in cognitive, behavioral, or emotional deficit in the person receiving the news that persists for some time after the news is received (1). The skill of the clinician in communicating bad news significantly impacts the patients’ satisfaction, adherence to treatment, and even their well-being (2).

It has been shown that patients’ preferences on the way to break bad news vary from those of the physicians (3). Patients prefer to obtain clear information about the progression and prognosis of disease, as well as about anticipated life expectancy, while in practice this information are not easily provided in clear terms. On the other hand, most clinicians felt they had difficulty in communicating the truth to patients, indicating their need for training on this aspect (4). The task of breaking bad news involves not only the mere provision of information, but also how to deal with the emotions of the patients and the response of their relatives. Therefore, certain communication protocols are employed for this process (5).

Some of the commonly used protocols are “BREAKS” protocol (Background, Rapport, Explore, Announce, Kindling and Summarize) (6), “SPIKES” protocol (Setting up interview, assessing patient’s Perception, obtaining patient’s Invitation, giving Knowledge and information to patient, addressing patient’s Emotions with empathic responses, and Strategy and Summary) (4), and “ABCDE” protocol (Advance preparation, Build a therapeutic environment/relationship, Communicate well, Deal with patient and family reactions, Encourage and validate emotions) (7). These protocols are preferably done in face-to-face settings with no physical barriers (8, 9). The emergence of the
coronavirus disease (COVID-19) in Wuhan, China in December 2019, which led to the global pandemic that caused more than 100 million infections globally; had posed unprecedented challenges on clinical practice (10, 11). The high potential of transmission of the disease necessitated the use of strict infection control measures including lock-down, quarantine, use of face-mask, as well as social distancing (12). These measures had changed the way health care providers communicate with the patients and their families, requiring the utilization of telecommunication technologies such as phones and video conferencing instead of in-person encounters (13). Most of the training on breaking bad news focus on face-to-face interaction with the patient and family, which is the favorable way of showing empathetic and caring attitude while delivering clear and honest information (14). This physical interaction is unfortunately not possible during the times of COVID-19 pandemic.

2. OBJECTIVE

The aim of this study was to assess the use on non-physical methods in breaking bad news by physicians and to evaluate the need for more development and training.

3. SUBJECTS AND METHODS

This study is a cross-sectional survey conducted in Kufa Medical College Al-Najaf during the period from April 2021 till the end of June 2021. The study included total of (60) physicians of various specialties working in that hospital who agreed to participate. The data was collected using specially designed questionnaire that included 12 questions, and collected information was treated with confidentiality. Participants were asked not to write their names or any other private information.

Statistical analysis
Statistical analysis was performed using SPSS® software (version 23.0 For Linux®; IBM, Armonk, NY, USA) and R Statistical Software (version 3.6.3 for Linux®; R Foundation for Statistical Computing, Vienna, Austria). Continuous variables were represented as means ± SD while categorical variables were represented as frequencies and percentages. Categorical variables were compared using chi-square test. P-value of ≤ 0.05 was considered statistically significant.

4. RESULTS

Age of participants ranged from 24 years to 50 years with a mean age of 27.68±4.55 years, females represented 60.0% of the total study participants (Figure 1). About one-third of the participants 35.0% worked in surgical specialty, while 31.7% worked in medical specialty, the remaining 33.3% worked in accidents and emergency (A and E) specialty.

All emergency physicians reported they had to break bad news regularly during their shifts in COVID-19 times, while 84.2% and 81.0% of medical and surgical physicians reported so, respectively (Table 1), however, those differences in proportions were not statistically significant (Fisher exact P-value = 0.124).

Majority of study participants 78.3% did not use any specific protocol for breaking bad news, or did not know what protocol to use. A small proportion 16.7% used “BREAKS” protocol, while only three participants 5.0% used “ABCDE” protocol (Table 2).

Less than half of the study participants 46.7% had received training on breaking bad news in general. No significant relationship was observed between specialty and receiving training on breaking bad news, P-value = 0.880 (Table 3). Approximately two-thirds of the physicians who received training did so using online courses. Significant relationship was observed between receiving training and the protocol used (P-value = 0.003), as detailed in Table 4.
In the present study, the majority of participants 88.3% reported their regular need to break bad news, but only 21.7% of participants did report they used specific protocol for doing so (namely, “BREAKS” protocol or “ABCD” protocol). The study by Monden et al. conducted in the Department of Surgery at Baylor University Medical Center, Dallas had revealed that more than 90% of participants considered the skill of delivering bad news to be a very important aspect in the practice, but only 43% believed they had received the necessary training to do so (7). A significantly larger proportion of those participants in the present study who did not follow a particular protocol for breaking bad news had not received training on breaking bad news. Overall, the proportion of participants who received formal training on breaking bad news was slightly less than half 46.7% of the participants. This is comparable to the study conducted by Alshami et al. in 2020, in which only (33.4%) of participants had reported that they received formal training on breaking bad news (15). The limitation in the proper training among healthcare providers may limit the communication capability between them and the patient. Improvement of these skills can be achieved through well-structured programs for training that provide appropriate mechanisms for feedback (16).

In addition, only 13.3% had received specific training for non-physical breaking bad news, and significantly larger proportion preferred face-to-face approach over non-physical approach. The importance of non-physical communication of bad news has been clearly emphasized during the era of COVID-19 pandemic; when the face-to-face communication became restricted due to the application of social distancing policies. Modern digital technologies can provide effective video-conferencing methods as an alternative way of communication between healthcare providers, patients, and their relatives (17, 18).

For the remote communication of bad news during COVID-19 times (whether through telephone or video-conference), Landa-Ramirez et al. had proposed a protocol consisting of four categories (preparation, notification, closure, and self-care) organized in nine steps. This protocol aims to provide a systematic tool that can be used by healthcare providers to communicate bad news even when face-to-face meeting is not possible (19). Vitto et al. had suggested certain adaptation to the traditional "SPIKES" protocol to be appropriate for remote encounters using video conferencing. These adaptation include: the importance of preparing backup device and contact information in case of technical failure during the call, ensuring that the patient and/or relatives are in an appropriate environment for receiving the news (not driving, for example), encouraging the proper positioning of the camera to allow for eye contact as close as possible, exaggeration of body language movements, making extra effort to understand the patient and/or relatives body language, and be prepared to provide more information than usual (20).

5. DISCUSSION

In the present study, the majority of participants 88.3% reported their regular need to break bad news, but only 21.7% of participants did report they used specific protocol for doing so (namely, “BREAKS” protocol or “ABCD” protocol). The study by Monden et al. conducted in the Department of Surgery at Baylor University Medical Center, Dallas had revealed that more than 90% of participants considered the skill of delivering bad news to be a very important aspect in the practice, but only 43% believed they had received the necessary training to do so (7). A significantly larger proportion of those participants in the present study who did not follow a particular protocol for breaking bad news had not received training on breaking bad news. Overall, the proportion of participants who received formal training on breaking bad news was slightly less than half 46.7% of the participants. This is comparable to the study conducted by Alshami et al. in 2020, in which only (33.4%) of participants had reported that they received formal training on breaking bad news (15). The limitation in the proper training among healthcare providers may limit the communication capability between them and the patient. Improvement of these skills can be achieved through well-structured programs for training that provide appropriate mechanisms for feedback (16).

In addition, only 13.3% had received specific training for non-physical breaking bad news, and significantly larger proportion preferred face-to-face approach over non-physical approach. The importance of non-physical communication of bad news has been clearly emphasized during the era of COVID-19 pandemic; when the face-to-face communication became restricted due to the application of social distancing policies. Modern digital technologies can provide effective video-conferencing methods as an alternative way of communication between healthcare providers, patients, and their relatives (17, 18).

For the remote communication of bad news during COVID-19 times (whether through telephone or video-conference), Landa-Ramirez et al. had proposed a protocol consisting of four categories (preparation, notification, closure, and self-care) organized in nine steps. This protocol aims to provide a systematic tool that can be used by healthcare providers to communicate bad news even when face-to-face meeting is not possible (19). Vitto et al. had suggested certain adaptation to the traditional "SPIKES" protocol to be appropriate for remote encounters using video conferencing. These adaptation include: the importance of preparing backup device and contact information in case of technical failure during the call, ensuring that the patient and/or relatives are in an appropriate environment for receiving the news (not driving, for example), encouraging the proper positioning of the camera to allow for eye contact as close as possible, exaggeration of body language movements, making extra effort to understand the patient and/or relatives body language, and be prepared to provide more information than usual (20).

6. CONCLUSION

Although COVID-19 necessitate the utilization of non-physical breaking bad news techniques; high proportion of physicians lack the necessary skills to do so, and many of those who have the required knowledge do not prefer non-physical breaking bad news. Well-structured programs for training of communicating bad news-especially using remote techniques- are necessary for the training of healthcare providers, and certain adaptations are needed for the traditional protocols to be more
appropriate for breaking bad news remotely using telephone or video conferencing.

- **Acknowledgment**: The authors would like to express our thanks to Dr. Mustafa Wahhudi for his assistance in performing statistical analysis of this study.

- **Author's contribution**: All authors were involved in all steps of preparation this article. Final proofreading was made by the first author.

- **Conflict of interest**: None declared.

- **Financial support and sponsorship**: Nil.

**REFERENCES**


