Assessment of Attitude and Practices Toward Breaking the Bad News Among Physicians in a National Tertiary Government Hospital for Infectious Diseases from October 2020 to October 2021

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Background: Delivering bad news to patients is one of the most difficult tasks of physicians that play a big role in the process of treatment and cooperation of patients. Patients generally have the right to be informed of their condition, but the debate over the importance of the attitude of telling the truth is still an issue.
Objective: This study aimed to understand the attitude and practices toward breaking the bad news among physicians in a National Tertiary Government Hospital for infectious Diseases from October 2020 to October 2021.
Methods: This cross-sectional study was conducted at the San Lazaro Hospital from October 2020 to October 2021. A self-administered questionnaire was adapted to elicit information on physicians' knowledge and practices about breaking bad news to patients and their families.
Inclusion criteria included all the practicing physicians assigned in the clinical areas either full time or part time medical specialists, residents and fellows and hospitalist in San Lazaro Hospital. Physicians who were assigned in the non-clinical areas and did not see or handle patients and non-employees of the institution and who refused to sign the informed consent were excluded. Total Purposive Sampling was utilized. Data were gathered using a validated 3-part 34 item personally administered questionnaire and was presented in Descriptive Statistics Frequency distribution for the demographics, ANOVA, Linear regression analysis.
Results: A total of 100 participants was included and based on socio-demographic characteristics of respondents toward breaking the bad news. Majority of the respondents were aged 35 – 54 years old with 52 or 52%, female with 69 or 69%, were fellows with 41 or 41%, specialty was Family Medicine with 36 or 36%, and majority of the respondent's qualification was GP with training with 46 or 46%. The study revealed that sex ($t = -2.070$, $p = 0.042$) had significant association to the attitude and practices toward breaking the bad news among practicing physicians at 0.05 level of significance. Thus, male respondents has had higher attitude and practices toward breaking the bad news as compare to female respondents.
Conclusion: According to the findings of this study, clinicians at San Lazaro Hospital demonstrated a good attitude and practice regarding breaking the bad news between October 2020 and October 2021. The researcher believed want to help their patients, and most of them have the necessary knowledge and skills for breaking bad news.

Key words: truth telling, bad news, attitude, practices

Introduction

San Lazaro Hospital is a Special National Hospital for Infectious Diseases and caters to the greatest number of communicable diseases in the country and consequently has plenty of clinical bad news, but only a few of empirical studies about communicating such information to patients and families have been studied. Practicing patient- centered approach care is somehow an issue nowadays and should require training especially in such situations of patients wherein they should actively participate in the decision-making process. Bridging bad news is an important matter because we are considering the rights of the patients thus physicians should let them understand their condition first before making decisions and at the same time so doctors can aim for them to participate.

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Practices and perspectives concerning truth telling are not immune from the health-seeking behaviors, beliefs, traditions, values, and social structures of any society and Philippines being a developing country is an ideal example to study the complexities of breaking bad news. Although it is a promising country in the global economy, Philippines is still a country which has significantly higher number clinical bad news because comparing to its neighboring countries it has higher number of incidences of infectious diseases. According to Edillo F, et al., It is ranked 4th in dengue burden in Southeast Asia.[1] This is also evident during the statistics released by the WHO on COVID 19 cases. Among its 108 million people, Philippines is ranked 22nd out of 188 countries with 161,253 confirmed cases as of August 20, 2020. In 2015, Philippines has the most rapidly escalating cases of HIV or AIDS and according to Department of Health, In 2010, TB was the 6th leading cause of mortality with a rate of 26.3 deaths for every 100,000 population and accounts for 5.1% of total deaths. The country has reported outbreaks of diphtheria, measles, and polio. For diphtheria, the Department of Health has reported 197 cases with 47 deaths through October 5, 2019, an increase in cases of 47% compared with the same period in 2018. In the same year, health officials have also reported more than 42, 200 measles cases up to early October. In addition, measles complications were responsible for 560 deaths. More than eight out of ten people affected by the measles outbreak were children aged 4 years and younger. For polio, four cases caused by infection with vaccine-derived poliovirus have been reported in the country, which had been polio-free for 19 years.

Patients would like doctors who can diagnose and treat their illnesses as well as communicate with them effectively. The aim of this study was to explore physician's perspectives and their practices in relation to breaking the bad news to patients.

This study aimed to understand the attitude and practices toward breaking the bad news among physicians in a National Tertiary Government Hospital for infectious Diseases from October 2020 to October 2021.

Methods

Cross-sectional study at San Lazaro Hospital from October 2020 to October 2021. A self-administered questionnaire was adapted to elicit information on physicians' knowledge and practices about breaking bad news to patients and their families.

Inclusion criteria included all the practicing physicians assigned in the clinical areas either full time or part time medical specialists, residents and fellows and hospitalist in San Lazaro Hospital. Physicians who were assigned in the non-clinical areas and did not see or handle patients and non-employees of the institution and who refused to sign the informed consent were excluded.

Total Purposive Sampling was utilized. Data were gathered using a validated 3-part 34 item personally administered questionnaire and was presented in Descriptive Statistics Frequency distribution for the demographics, ANOVA, Linear regression analysis.

Results

Table 1 shows the socio-demographic characteristics of respondents toward breaking the bad news among physicians in a National Tertiary Government Hospital for Infectious Diseases. A total of 100 participants were included and based on socio-demographic characteristics of respondents toward breaking the bad news. Majority of the respondents were aged 35 – 54 years old with 52 or 52%, female with 69 or 69%, were fellows with 41 or 41%, specialty was Family Medicine with 36 or 36%, and majority of the respondent's qualification was GP with training with 46 or 46%.

Table 2 shows that the respondent's answer on "attitude and practices toward breaking the bad news of physicians". Based from the results, "Q25. Inform the patient that he/she is free to seek a second opinion." had the highest mean score of 4.91 with a standard deviation of 0.32 or interpreted as strongly agree while "Q1. I usually avoid telling my patients about their final diagnosis." had the lowest mean score of 1.89 with a standard deviation of 0.47 or interpreted as disagree. In summary, the respondents' answer on "Attitude and Practices Toward Breaking the Bad News of Physicians" has an overall mean of 3.49 with a standard deviation of 0.19 or interpreted as agree.

Table 1. Socio-demographic characteristics of the respondents.

Characteristics		Frequency (n=100)	Percentage (%)
Age in years	25-34	43	43%
	35-54	52	52%
	55-65	3	3%
	No answer	2	2%
Sex	Female	69	69%
	Male	30	30%
	No answer	1	1%
Clinical Position	Fellow	41	41%
	Resident	29	29%
	Hospitalist	21	21%
	Medical Specialist	7	7%
	No answer	2	2%
Specialty	Family Medicine	36	36%
	Pediatrics	25	25%
	Internal Medicine	4	4%
	Others	34	34%
	No answer	1	1%
Qualification	Fellow	38	38%
	Diplomate	6	6%
	Master's degree	5	5%
	GP with training	46	46%
	Master's degree and with GP training	2	2%
	Master's degree and Fellow	1	1%
	No answer	2	2%
Participant's preference whom to break bad news	The Patient	77	77%
	His/Her family	19	19%
	The Patient and His/her Family	4	4%

Table 2. Attitude and practices toward breaking the bad news of physicians.

Attitude and Practices Toward Breaking the Bad News of Physicians	Mean	Std. Dev.	Interpretation
Q1. I usually avoid telling my patients about their final diagnosis.	1.89	0.47	Disagree
Q2. I face difficulty in deciding what to say when I try to break bad news to a patient.	2.19	1.04	Disagree
Q3. It is really difficult "how to say," i.e how to break the bad news.	2.12	1.00	Disagree
Q4. I cannot tolerate the patient's reactions to the news.	2.06	0.94	Disagree
Q5. The patient always has the right to know his/her diagnosis.	4.85	0.50	Strongly Agree
Q6. For elderly patients, it is sufficient to inform the caregivers about the bad news.	3.34	1.57	No Difference
Q7. I would tell the patient even if the family objected.	3.82	1.40	Agree
Q8. At the time of breaking the bad news, having somebody (relative) attend will only complicate the situation.	2.18	0.78	Disagree
Q9. At the time of breaking the bad news, the fact that the patient is alone is not important.	1.90	0.85	Disagree
Q10. A doctor has no right to interfere with the patient's decision to come alone to the office.	3.05	1.26	No Difference
Q11. A multi-bed hospital room can be used to deliver the news.	2.68	1.15	No Difference
Q12. Deliver the news all in one blow and get it over with as quickly as in humanly possible.	3.08	1.24	No Difference
Q13. Before telling the bad news, a physician should give a "warning shot" that some bad news is coming.	3.73	0.74	Agree
Q14. Before telling the bad news, it is good to find out how much the patient already knows.	4.54	0.52	Strongly Agree
Q15. No need to find out how much the patient wants to know about his/her illness.	2.57	1.62	Disagree
Q16. Start by saying "I'm sorry, I have a bad news to tell you."	3.60	0.99	Agree
Q17. Doctor may say " I can't talk to you without your family here."	3.68	1.17	Agree
Q18. Every patient should be told everything about their condition.	4.62	0.60	Strongly Agree
Q19. In some instances, patients should not be told the full extent of their condition.	2.96	1.22	No Difference
Q20. Before the patient leaves the office, ask about his/her fears.	4.43	1.02	Strongly Agree
Q21. Before the patient leaves the office make sure the patient fully understands the news that was given to him/her.	4.81	0.44	Strongly Agree
Q22. Before the patient leaves the office make sure you give the patient a follow-up plan and provide him/her some hope.	4.78	0.73	Strongly Agree
Q23. Before the patient leaves the office make sure he/she understands all details of his prognosis.	4.71	0.46	Strongly Agree
Q24. Before the patient leaves the office make sure that you have left no question unanswered.	4.85	0.56	Strongly Agree
Q25. Inform the patient that he/she is free to seek a second opinion.	4.91	0.32	Strongly Agree
Overall Mean	3.49	0.19	Agree

Table 3 showed that sex ($t = -2.070$, $p = 0.042$) had significant association to the attitude and practices toward breaking the bad news among practicing physicians at 0.05 level of significance. Thus, male respondents has had higher attitude and practices toward breaking the bad news as compare to female respondents.

However, age ($F = 2.450$, $p = 0.091$), clinical Position ($F = 1.870$, $p = 0.140$), specialty ($F = 2.400$, $p = 0.073$), qualification ($F = 2.170$, $p = 0.064$), and preference ($F = 0.630$, $p = 0.535$) was had association to the attitude and practices toward breaking the bad news among practicing physicians but not on a significant extent.

Discussion

Relative to the result of previous study of Al Mohaimeed, et al.[2] regarding to the age of the participants, it reveals that junior physicians received better ratings than elders, it may assume that a greater number of medical educational systems are incorporating training on delivering bad news in their curricula, reflecting increased awareness of this need within healthcare. The researcher also found out that male respondents have higher attitude and practices toward breaking the bad news as compared to female respondents.

In a study of Volk, et al., Men are more likely to make extreme choices and decisions than women, however, it would interpret these results with caution, as adequate sampling to assure generalizability was not ensured. The percentage of healthcare providers formally trained remains modest relative to the anticipated need. A study of Childmann J, et al.[3] in Germany reveals that pre-registration house officers (PRHOs) are regularly involved in conveying negative news. Their sense of competency would indicate that the comprehensive and compulsory

Table 3. Association of attitude and practices toward breaking the bad news among practicing physicians.

Variables		Mean	SD	F-value	p-value	Decision	Remarks
Age	25 to 34	3.53	0.14	2.450	0.091	Do Not Reject Ho	Not Significant
	35 to 54	3.48	0.21				
	55 to 65	3.31	0.35				
Clinical Position	Fellow	3.54	0.19	1.870	0.140	Do Not Reject Ho	Not Significant
	Hospitalist	3.46	0.12				
	Medical Specialist	3.39	0.22				
	Resident	3.49	0.21				
Specialty	Family Medicine	3.45	0.22	2.400	0.073	Do Not Reject Ho	Not Significant
	Internal Medicine	3.37	0.17				
	Pediatrics	3.49	0.12				
	Others	3.55	0.19				
Qualification	Diplomate	3.37	0.13	2.170	0.064	Do Not Reject Ho	Not Significant
	Fellow	3.55	0.18				
	GP with Training	3.47	0.18				
	Master's Degree with Fellow	1.00	3.44				
	Master's Degree	3.38	0.26				
	Master's Degree GP with Training	3.34	0.20				
Preference	Family	3.50	0.26	0.630	0.535	Do Not Reject Ho	Not Significant
	Patient	3.50	0.17				
	Both	3.39	0.21				
Variables		Mean	SD	t-value	p-value	Decision	Remarks
Sex	Female	3.47	0.19	-2.070	0.042	Reject Ho	Significant
	Male	3.55	0.18				

undergraduate training they had received on this subject has worked to prepare them for this demanding task.

Findings of the study conducted by Al Mohaimeed, et al.[2] 70% of doctors preferred to deliver bad news to patients' relatives, this was perhaps because of cultural influences sometimes override professional considerations. Possibly that was the motivating factor for sharing patient information with relatives rather than the patient. Cultural aspects could strongly influence decision making practices about breaking bad news. Cultures where family bonds are strong and families are predominantly patriarchic, such as Saudi culture, place significant decision making with elders of the family without really caring about rights or privacy. Physicians must adhere to cultural norms. In the survey conducted at San Lazaro Hospital, the researcher found out that clinicians favored to deliver bad news to patients rather than their relatives. The underlying factor here is the possibility that the physicians are giving due importance to the patient who is the owner of the information. It was also found out that others choose to deliver in the presence of both patients and relatives because it might believe in treatment partners and they think that it is likely easier to share patient related information with the presence of families or relatives.

This survey revealed that most of the physicians strongly agree with patients seeking second opinion. This is possibly because second opinion services reflect positive consequences in terms of patient satisfaction and quality of care.

Conclusion and Recommendation

According to the findings of this study, clinicians at San Lazaro Hospital demonstrated a good attitude and practice regarding breaking the bad news between October 2020 and October 2021. The researcher believed want to help their patients, and most of them have the necessary knowledge and skills for breaking bad news. This study, like all studies and research, has limitations. It was imperative to understand that cross-sectional design of the study does not allow for adequate assessment of causality. Also, not all of the 184 practicing clinicians were surveyed, only 100 of them were included in the survey, so this could pose a possible sampling bias. Additional potential bias include administration bias as participants were involved in the survey collection process.

Despite the positive findings of this study, the researcher advised that San Lazaro Hospital implement a current training program for all practicing clinicians in general communication skills. In this way, the clinician can better assimilate the knowledge, attitudes and practices that needs to be addressed, implement their newly acquired skills in their clinics and bring their personal experience and dilemmas. All levels of practicing physicians should receive training in the abilities needed to deliver bad news. Also, a continuation of this research is highly encouraged with high number of sample data to be able to use for a more accurate generalization.

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