

*Original Article***Breaking Bad News for Patients with Gastro-Intestinal Malignancy:  
Experience at Ibn Sina Teaching Hospital**Elsiddek AM<sup>1\*</sup>, Eltayeib E<sup>2</sup>, Salahedin M<sup>3</sup>, Elbakhiet TA<sup>4</sup>, Ibnouf MAM<sup>5</sup>**ABSTRACT**

**Background:** Integrity, beneficence, non-maleficence and Justice are the pillars of the professional behaviour. Confidentiality is a serious issue governed by the law. However, in developing countries, patients' relatives urge to know the diagnosis and often request the doctor not to mention the word cancer or malignancy to their patient.

**Objectives:** To evaluate the communication skills for breaking bad news to Sudanese patients suffering of gastrointestinal cancer and to find out the patients' responses on that matter.

**Materials and Methods:** This is a hospital based non-randomized prospective study, carried out at Ibn Sina Specialized Hospital in the period August through December 2011. The study involved 113 patients of whom there were 56 males.

**Results:** Doctors had talked about the disease to 75% of the patients whereas the rest were told by either the psychologists and/or their relatives. Only 25% of the patients were told the truth, the rest were told to have mass or lump without explaining its nature. Patients' responses were as follows: 41.6% were felt terrified, 23.9% were shocked and became anxious, while 33.6% were stable, but 0.9% became angry and frustrated. No patient was told about the prognosis and the chances of cure.

**Conclusion:** Sympathy over-ride empathy in communicating bad news to Sudanese patients suffering of cancer. Patient education and training in breaking the bad news is needed.

**Key words:** Communication skills, breaking bad news, truth telling, Sudan.

**T**ruth telling practice and preferences is a cultural artefact to certain extent<sup>1</sup>. Honest and truthful disclosure is an extremely difficult task. Physicians often find the disclosure of cancer diagnosis to the patient as an embarrassing job.

Few healthcare workers have received sufficient training in the "breaking bad news" tactics<sup>2,3</sup>.

Bad news is defined as "one which is pertaining to situation where there is a threat to a person's mental or physical wellbeing, as a result of loss of hope. It carries a risk of upsetting the patients' lifestyle when a message is conveyed to an individual leaving

him/her with fewer choices in life<sup>4</sup>. Also, bad news is defined as: "Any news that drastically and negatively alters the patient's view of her or his future"<sup>5</sup>.

A number of empirical studies had documented that physician-patient communication as suboptimal. The main causes for physician's avoidance of the task of breaking bad news are lack of skills and the reluctance to deal with the patient's feelings<sup>6</sup>. With poor explanation, physicians and nurses typically miss the full range of concerns of patients suffering of cancer<sup>7</sup>. Feelings of mistrust, anger, fear, and blame are common reactions if bad news was broken poorly. This communication skill is typically learned through trial and error or observation of many doctors<sup>8</sup>.

The objective of this study is to evaluate the communication skills of breaking bad news to Sudanese patients suffering of gastrointestinal cancer and to find out the patients' responses on that matter.

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## **MATERIALS AND METHODS:**

This is a prospective, descriptive, non-randomised hospital-based study. It was performed in the period from August 2011 through December 2012.

**Set up:** It was carried out in the Surgical Gastroenterology Unit at Ibn Sina Specialized Hospital where major gastrointestinal surgery is performed.

**Selection criteria:** Patients with gastrointestinal malignancy who were admitted or seen in the referred clinic during the study period.

**Exclusion criteria:** Patients suffering from end-stage disease, disoriented or have hypotension were excluded.

Surgeons, registrars in their qualifying training programme communicated with the patients and/or their guardians to obtain consent for surgery. Thereafter, data on the patients' information, feelings and responses about his/her disease was collected using a pretested questionnaire.

**Statistical analysis:** Data were fed to Statistical Package for Social Sciences (SPSS). Descriptive statistical analyses were conducted.

## **RESULTS:**

During the study period 113 patients were diagnosed to have malignant gastrointestinal tumours. Of them 60% of were older than 40 years of age. The male to female ration was 1:1 and the educational level was similar in both sexes.

During breaking the bad news only 25% of the population of the study was told clearly that the cause of their disease is cancer. Of the rest, 40% of patients were told that the cause of their disease is "tumour" and about the same percent were told to have "lump", Three quarters of patients were told by doctors, whereas the remainders were told by the psychologist and/or their relatives.

Timing of breaking the bad news was after confirming the diagnosis in 71.7% patients, whereas 25.7% were told only during taking the consent for surgery. Nevertheless, 2.7% were found to know the correct diagnosis

before completing the in-hospital investigations. In addition almost all patients were not told about the chance of cure or prognosis of their malignancies. Regarding the patients' reactions 41.6% of the patients were felt scared, 23.9% shaken, upset, and even shocked, 33.6% were stable and 0.9% showed manifestations of depression.

Of the 29 patients who were told to have cancer, only four patients were stable, but the remaining 25 were either felt frightened or even shocked. In contrast, of those who were told to have "tumour" two thirds (44 patients) were shocked or afraid but one third (14 patients) were stable. When the word lump was used 40 patients were stable.

On the other hand, 95.6% of relatives knew the correct diagnosis either form the hospital doctors or from the referring doctors.

## **DISCUSSION:**

To our best of knowledge this is the first study to document the current status of breaking bad news among Sudanese patients suffering of gastrointestinal cancer. The vast number of complaints in the Sudan Medical Council could have been prevented by good communication skills between doctors in one side and patients and their relatives on the other side. Also, poor communications and even misunderstanding led to conflicts and intra-professional problems i.e. between doctors themselves. This adds to the slowly developing medical facilities compounded with lack of protocols and guidelines of management in the face of the great expectations of patients and their relatives, particularly the educated elites, makes handling of patient rather difficult.

Poverty, local customs and traditions of those who live in districts far from the capital of the country, lead to delay in diagnoses of cancer and hence advanced stage at presentation. The later has negative impact on hopes of patients, their relatives and the physicians themselves. However, some relatives were probably brainwashed by the local mass media, so tend to advise patients and their guardians to travel abroad to Jordan, Egypt and other countries claiming that they will get cured. This

misconception has been augmented by the spread of brokers and agencies that take commissions in helping patients to travel abroad for treatment. Unfortunately, not a single medical agency office is headed by a senior medical professional to reduce the injudicious high expenditure of the poor people travelling abroad to come back in despair.

In this study all of the participants were adults. This indicated that they are mature enough to be given truthful answers, but only 29 (25%) were told the correct diagnosis. This indicates that medical professionals need further training in to become empathetic rather than sympathetic. However, it is the right of the doctor to know how far the patient needs to know about his/her diagnosis. Some patients may not prefer, or may be illiterate to a degree that they do not benefit from, details about their disease. Yet, all patients should be helped to understand and helped in alleviating their own sufferings.

In our study there was no gender bias because the number of participants in both sexes was 1:1. Also, the level of education was comparable in both sexes. However, consent for treating adult females is usually given by their male guardians. This is because in Sudan males dominate females in lots of aspects of life, especially in decision making.

In this study, there seems to be some psychological barriers among doctors who deliver the bad news. This is why the vague words like "tumour" and "lump" are frequently used to describe the malignant disease to the patient. This difficulty is consistent with the previous reports in the literature<sup>9</sup>. Also, it could be attributed to the fact that there are real difficulties on breaking bad news like fear of upsetting recipients of bad news, fear of adverse responses of patients, or worry over questions that might be asked by patients and/or their relatives. However, frequently relatives beg doctors not tell the word "cancer or malignant" to their patients<sup>1,8</sup>. Nevertheless, our findings are consistent with that of Ozdogan M and Samur M in Turkey in 2003 who studied truth telling

for cancer patients; they found 48% doctors never prefer telling the truth<sup>10</sup>. To face such difficulties, our unit has recruited a female psychologist to help in breaking the bad news. In this study the psychologist was able to tell 25% of the patients. This dictates to exert more efforts in patients education and doctors training according to the international literature<sup>2,3</sup>.

The fact that 33.6% of our patients were stable when they received the correct diagnosis, indicates that our doctors have carefully considered the socio-psychological impacts on the patients<sup>12,13</sup>. Of those 29 patients who were told to have cancer only four patients were stable and accepted the truth.

Those who were told to have lumps (80 patients) 40 of them were shocked and became terrified on receiving the diagnosis. The fact that some of our patients were afraid and shocked is not any different from the others<sup>13</sup>.

In our study we found that females were more liable to be shocked and terrified (49 females) compared to (22) males. This could be explained by the cultural impact on females as well as the nature of the female herself being more sympathetic.

In spite of the previously mentioned weaknesses 96 % of the relatives knew the real diagnosis of malignancy of their patient. This indicates that our doctors has a high professional behaviour in being truthful and empathetic and respect the patient feelings. However, the word relative should legally be qualified for the guardian of the patient and/or those who he request to be involved in the decision of his/her treatment.

On the other hand, almost all the patients were not told the chance of cure and the prognosis of their malignancies. This is keeping with the report of Shahidi Jin<sup>14</sup> who concluded that, despite the general agreement on the benefits of open communication between physicians and cancer patients, there is still strong resistance against disclosure of cancer diagnosis and prognosis in many cultures. The fear of causing psychological

trauma to patients and their own reluctance not to find out the truth are two main excuses for the non-disclosure attitude.

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