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Research Article

Patients' Preferences in Breaking Bad News: A Cross-Sectional Study

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Abstract:

Background: Doctors and patients communicating effectively is a very important base in cancer clinics and out-patient, the "Bad" news is any information that drastically alters a patient's prospect of their life and forthcoming possibilities. It includes facts about diagnosis, recurrence, and treatment failure in clinical oncology settings.

Objective: To assess the attitudes of cancer patients toward receiving bad news of their condition and the relationships of some sociodemographic variables to these attitudes.

Methods: A cross-sectional study was conducted from the 19th of February to the 1st of June 2017 at the Oncology Hospital in the Medical City Teaching Centre/Baghdad. A group of 212 cases completed the questionnaire, which included socio-demographic information (age, gender, marital status, occupation, and education). The preference and attitude questions were set as in the recommended steps of the SPIKES protocol, which is a six-part method for sharing bad news with patients (Setting, Perception, Invitation, Knowledge, Emotions, and Summary).

Result: Patients were classified into two age groups: those 50 years or older (64.2%) and those below 50 years (35.8%). Of the 212 cases, 46.2% were housewives, and 20.8% were government employees. The majority of patients (80.2%) preferred to be informed about their disease, its type, its prognosis, treatment, and life expectancy on the first visit. Most of the participants (67.9%) thought that the most experienced and skilled doctors have to notify them completely about their medical condition. The majority of them (81.1%) preferred that the physician use the word (disease) instead of "cancer. Most patients (75.5%) thought that it is better to train healthcare professionals in communication skills and how to break bad news.

Conclusion: Patients diagnosed with cancer are willing to learn about the diagnosis and are keen to receive details as early as possible about its type and prognosis, treatment, and life expectancy.

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Keywords: Breaking Bad News; Cancer; Communication; Health care setting; SPIKES.

Introduction

Effective communication between physicians and patients is an important aspect of oncology care units, especially when bad news is being carried which includes all the information regarding the diagnosis, recurrence, and any treatment success / failure in clinical oncology settings (1).
In the medical context, bad news is any news that drastically and negatively alters the patient's view of the future (2). Bad news means the kind of information that starts a new life for the patient. Breaking this kind of news is a difficult task for every physician, independent of the specialty (3). How physicians communicate bad news about cancer can affect the degree of the patient's distress in response to that news (4). In the past, recommendations on how to break the bad news of a cancer diagnosis have been based on the expert opinion of the physician. Recently, consensus-based guidelines for medical practitioners have been developed (5).

The oncology team needs to develop expert communication skills, especially when delivering bad news to patients and families. Patients and families differ in their needs for levels of information, interpretation of information delivered to them, and responses to unfavorable news according to their cultural background (6). When bad news is delivered in a sensitive, ethical, and caring manner morals can be maintained, and the process of breaking bad news about cancer or death is possible through realistic expectations and hope. It is valuable for physicians to give time to patients or family members to understand what is happening to them, and what they need which is so important in the process of communicating in such times (7). Also, the skill in responding to feelings and not the content of expression is necessary in such a situation. So many improved cancer treatments exist, but the goal of effectively communicating with respect and caring is just as important as treating patients with cancer (8). Cancer patients reporting high levels of perceived injustice

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are at greater risk of feeling psychologically distressed. Prevention and management of injustice perceptions may require interventions targeting specific negative attributions, as well as cancer care in general (9). Poor communication with cancer patients is associated with worse clinical and psychosocial outcomes, including worse pain control, worse adherence to treatment, confusion over prognosis and not being involved in decision-making. For physicians, communication difficulties and barriers lead to job dissatisfaction and higher stress levels, as well as being behind a high proportion of errors and complaints (10). On the other hand, the problems physicians face when communicating bad news to their patients include a lack of adequate time, being honest without causing distress, dealing with the patients' families, responding to patients' emotions, and discussing life expectancy (11).
Buckman developed an easily learned protocol for breaking bad news that is sensitive to each patient's individual needs and emotional reaction (12, 13).
The SPIKES protocol is the most widely held guideline (14), using a six-step in conventions for delivering bad news with special modifications for cancer patients (15). It was assessed for the delivery of bad news in the United States and several other countries, then recommended and considered as a guideline (16, 17).
The current study aimed to assess the attitudes of cancer patients toward receiving bad news of their condition, and the relationships of some sociodemographic variables to these attitudes.

Patients and methods
This descriptive cross-sectional study was conducted at the Oncology Hospital in Medical City Teaching Center, Baghdad, from the 19th of February to the 1st of June 2017. A convenient sample of 220 patients with cancer attending the Oncology Teaching Hospital for treatment, clinical follow-up or opinion in the outpatient setting was recruited for the study.
Inclusion criteria
- Patient diagnosed with cancer at least one month earlier to give them enough time to cope with accepting the idea of the diagnosis and to reflect on their experience.
- Eighteen years of age or over.
- Arabic speaking.

Exclusion criteria
- Patients with psychiatric disorders or serious cognitive impairment.

Response rate from the 220 patients recruited: 6 refused to participate, and 2 did not complete the interview because they were not interested in this study. The remaining 212 patients completed the questionnaire. The response rate was 96.3%.
Data collection:
A questionnaire form was compiled from different published research and textbook references by the researcher in consultation with the supervisor and an oncology specialist, and then evaluated by three family medicine specialists.
The questionnaire included socio-demographic information (age, gender, marital status, occupation, and education) and consisted of 21 questions: Nine questions about preferences, nine questions about the attitudes on receiving the bad news about their diagnosis and 3 questions on patient’s satisfaction regarding medical efforts used for breaking bad news for them. The preference and the attitude questions were set according to the recommended steps of the six-part method for sharing bad news with patients’ (Setting, Perception, Invitation, Knowledge, Emotions, and Summary), SPIKES protocol (14).
The questionnaire requested patients to recall the time when they were first told that they had cancer. It contained different aspects of preferences and attitudes regarding the consultation: Diagnosis, treatment options, prognosis, and other issues, including family support and psychological assessment. Patients were asked to report their actual experiences and their preferences for these issues. The questionnaire was written in Arabic and explained by the researcher to all participants. The interview took from 10 to 15 minutes, varying according to the patient's educational level and feelings about their diagnosis.

Ethical consideration
An official approval was obtained from Medical City and Oncology Teaching Hospital. Patients were approached in the waiting room before their appointment, when the study was briefly described, and they were asked to participate. Oral consent was obtained from each patient, and the purpose of the study was explained before the interview to ensure the confidentiality of the data. Patients who consented to participate completed the questionnaire while waiting for their appointments.

Statistical analysis
The Statistical Packages for Social Sciences (SPSS) version 20 was used for data analysis; frequencies and percentages were used to represent the categorical data. The Chi-square test or Fischer exact test, whenever applicable was used to test the association between variables. A P-value ≤ 0.05 was considered statistically significant.

Results
Of the total of 212 cancer patients enrolled, there were 146 (68.9%) females and 66 (31.1%) males, with those $\geq$ 50 years accounting for 136 (64.2%) cases and those < 50 years to 76 (35.8%) cases. The majority of patients, 144 (67.9%) were married, 36 (17%) were single, 30 (14.2%) were widows, and 2 (0.9%) were divorced. The highest percentage of the patients were housewives, 98 (46.2%), while 44 (20.8%) had a governmental job, 10 (4.7%) had a non-governmental job, 24 (11.3%) were unemployed, and 36 (17%) were retired**.** The highest percentage of the patients, 82 (38.7%), had primary level education, 60 (28.3%) had secondary education, 42 (19.8%) were university graduates, 26 (12.3%) were illiterate,

and only 2 (0.9%) had a post-graduate education, Table 1.

Table 1: Distribution of the cases by sociodemographic characteristics

Variables	Categories	Number	%
Age group (years)	<50	76	35.8
	≥50	136	64.2
Gender	Female	146	68.9
	Male	66	31.1
Marital status	Single	36	17.0
	Married	144	67.9
	Divorced	2	0.9
	Widow	30	14.2
Occupation	Governmental	44	20.8
	Non-governmental	10	4.7
	Housewife	98	46.2
	Unemployed	24	11.3
	Retired	36	17.0
Education	Illiterate	26	12.3
	Primary	82	38.7
	Secondary	60	28.3
	University	42	19.8
	Higher study	2	0.9
Total		212	100.0

The highest percentage of patients, 96 (45.3%), had breast cancer, followed by lung cancer, 22 (10.4%), pancreatic cancer, 12 (5.7%), colon and liver, 10 each (4.7%), and other cancers, Table 2.

Table 2): Distribution of the cases by the type of cancer

Type of tumor	Number	%
Breast	96	45.3
Lung	22	10.4
Pancreas	12	5.7
Colorectal cancers	16	7.5
Liver	10	4.7
sarcomas	12	5.7
upper GIT	12	5.7
Gynecological	12	5.7
genitourinary ca	20	9.4
Total	212	100.0

Figure 1 shows the preference of patients as to the gender of the health professional to break the bad news. It shows that 10.3% of the patients prefer a female professional, 16.2% prefer a male professional, while 73.5% did not have a preferred physician's gender to break the bad news.

Age group <50 yrs. n. 136
better to be told about your diagnosis of cancer
by a physician/gender:

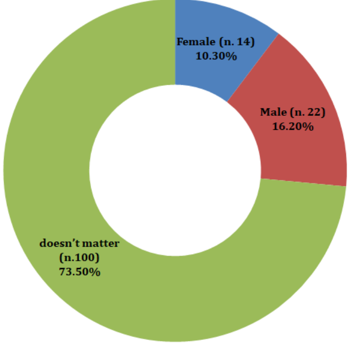

Figure (1): Distribution of the patients by their preference as to which gender of physicians to break bad news

The patient's preferences were recorded regarding many aspects involved in bad news delivery: The first of these aspects was the person who break the bad news, where the majority of patients 144 (67.9%) preferred to be informed about their disease by a specialist physician and 54 patients (25.5%) preferred to be informed by a family member. only 2 (0.9%) preferred a relative and 12 (5.7%) did not mind who the informer is. Regarding the need for a company during bad news delivery, 158 patients (74.5%) preferred a family member to be with them, while 22 (10.4%) want to be alone at the time of disclosing the diagnosis, 30 (14.2%) did not mind who is present and only 2 (0.9%) preferred to be with friend. The majority of patients 192 (90.6%) preferred their doctor to know how much information they have about their condition before telling bad news and 20 (9.4%) did not mind that. When the patients were asked if they preferred the doctor to ask about their feelings before telling the news, the majority, 194 (91.5%), agreed. The majority of patients, 128 (60.4%), preferred that their psychological status be considered while telling bad news. When patients were asked if they preferred to be told gradually that they had cancer, 198 (93.4%) agreed, 2 (0.9%) disagreed, and 12 (5.7%) did not mind. Regarding patients' preferences not to be informed that they have cancer in the first visit, 168 (79.3%) of them agreed, 38 (17.9%) disagreed, and 6 (2.8%) said that it does not matter. When considering patients' awareness, 170 (80.2%) preferred to be informed in detail about their disease type, prognosis, treatment, and life expectancy in the first visit and 10 (4.7%) disagreed, and 32 (15.1%) said that it does not matter. The majority of patients, 172 (81.1%), preferred that their doctor use the word "disease" instead of the word "cancer", Table 3.

Table (3): Distribution of patients' preferences regarding breaking bad news

Questions	Answers	%
Do you prefer to be informed about your disease first by	Specialist physician	67.9%
	Family member (brother, sister, etc.)	25.5%
	Relative	0.9%
	Friend	0.0%
	Doesn't matter	5.7%
Who do you prefer to be with you when you tell them about your disease?	Alone	10.4%
	Family member	74.5%
	Friend	0.9%
	Medical stuff	0.0%
	Doesn't matter	14.2%
You prefer that the physician know how much information you have about your condition before telling bad news	Agree	90.6%
	Disagree	0.0%
	Doesn't matter	9.4%
You prefer that the physician asks you first about your feeling	Agree	91.5%
	Disagree	0.0%
	Doesn't matter	8.5%
You prefer to that the physician considers your psychological status while telling bad news	Agree	60.4%
	Disagree	0.0%
	Doesn't matter	39.6%
	Agree	93.4%
	Disagree	0.9%

You prefer to be told gradually (in small parts) that you that you have cancer	Doesn't matter	5.7%
You prefer not to be informed that you have cancer in the first visit	Agree	79.3%
	Disagree	17.9%
	Doesn't matter	2.8%
You prefer to be informed in detail about your disease type, prognosis, treatment, and life expectancy in the first visit	Agree	80.2%
	Disagree	4.7%
	Doesn't matter	15.1%
You prefer that the physician use the word "disease" instead of the word "cancer."	Yes	81.1%
	No	0.0%
	Doesn't matter	18.9%

The patients' attitudes were recorded regarding nine questions (1st one was with two parts) involved in bad news delivery; the first of these aspects was about the gender of a physician who breaks the bad news; the majority, 142 (67%) didn't have a preference, Figure 1. As for the age of the informant physician, 174 (82.1%) didn't have a preference, while 36 (17.2%) said that they prefer an older physician. Most of the patients, 174 (82.1%), preferred to be told in a private hospital room. Almost all of the patients, 206 (97.2%), thought that ensuring privacy and adequate time is important while breaking the bad news of their disease. The vast majority of patients, 202 (95.3%), thought that the physician should summarize what had happened to date and check with them before breaking the bad news. The majority, 160 (75.5%), thought that they should be completely aware of their illness. The need for psychiatric assessment was said to be present by 76 (35.8%), and thought that the availability of psychiatric consultation is necessary while breaking bad news, while 130 (61.3%) said it didn't matter. Regarding the effect of the informant physician's experience, almost all of the patients, 210 (99.1%) thought that the physician's experience would affect their compliance during receiving bad news. When the patients were asked if it was difficult to be told about a cancer diagnosis, 160 (75.5%) thought that breaking bad news about cancer is considered more difficult than other diseases. The majority of patients, 160 (75.5%), thought it was better to train physicians and paramedical staff about communication skills and how to break bad news to patients with cancer.

Table 4: Distribution of patients' attitudes regarding breaking bad news

Questions	Answers	%
Do you think it's better to be told about your diagnosis of cancer by a "physician's gender"	Female	11.3%
	Male	21.7%
	Doesn't matter	67.0%
Do you think it is better to be told about your diagnosis of cancer by a "physician age"	Young	0.9%
	Old	17.0%
	Doesn't matter	82.1%
Where do you think it is better to be told about your disease?	Hospital in the private room	82.1%
	Outpatient with other patients	6.6%
	Doesn't matter	11.3%
You think that ensuring privacy and adequate time is important while telling bad news of your disease	Agree	97.2%
	Disagree	0.0%
	Doesn't matter	2.8%
The physician should summarize what happened to date and check with you before telling bad news	Agree	95.3%
	Disagree	0.0%
	doesn't matter	4.7%
You think that you should be completely aware of your illness	Agree	75.5%
	Disagree	0.9%
	Doesn't matter	23.6%
You think the availability of psychiatric consultation is necessary while telling bad news	Agree	35.8%
	Disagree	2.8%
	Doesn't matter	61.3%
The physician's experience will affect your compliance during receiving bad news	Agree	99.1%
	Disagree	0.0%
	Doesn't matter	0.9%
Breaking bad news of cancer is considered more difficult than other diseases	Agree	75.5%
	Disagree	0.9%
	Doesn't matter	23.6%
You think it is better to train physicians and paramedical staff about communication skills and how to break bad news to patients with cancer	Agree	75.5%
	Disagree	20.7%
	Doesn't matter	3.8%

The majority of patients answered with "yes," 156 (73.6%), when asked if the physician gave them a warning shot that something bad would happen. The majority, 166 (78.3%), received the bad news from physicians, and when asked if this person was skilled enough for that, the majority, 184 (86.8%) answered with "yes".

Table 5: Distribution of patients' answers regarding the warning shot and disclosure of the disease

Questions Answers		n%
Did the physician give you a warning shot that something bad would be told?	Yes	73.6%
	No	26.4%
Who disclosed the news to you about your disease?	Relatives	21.7%
	Friends	0.0%
	Physicians	78.3%
	Paramedical staff	0.0%
Do you think that this person was skilled in breaking bad news about your condition?	Yes	86.8%
	No	13.2%

Discussion

Breaking bad news and the doctor-patient conversation process is a dedicated and challenging task for physicians, requiring communication and social skills, extraordinary management, and obligation (18). Thus, several recommendations for breaking bad news have been established, the most popular being the SPIKES protocol and its application to oncology unit patients (19). The current study recognized and described patients' preferences and attitudes regarding how they would like to be told bad news on a diagnosis of cancer by their physician. It is one of the few studies that have focused on patients' priorities as the recipients of this news instead of the physicians' perspectives.

The finding that the patients in the current study want to be well-informed about the type of cancer, its prognosis, types of treatment, and life expectation is similar to the study of von Blanckenburg et al (16) who reported that 83% of their patients believed that they should be completely aware of their cancer, and that of Akalu et al (17) who reported that 87% of their patients wanted to be given all information. A higher

percentage was found in Saudi Arabia in 2015 (21), as 98% of patients preferred to know most of the information about their diagnosis, outcome, treatment, and prognosis. A study conducted in Iran in 2016 (19) showed that 90.8% of patients believed they should be informed about their disease and receive unwelcome news.

In the current study, most of the patients preferred to be informed by a specialist physician, similar to the findings of von Blanckenburg et al (16), which showed that 69.3% of patients thought that the specialist physician is the best person to convey the bad news. A study conducted in Saudi Arabia (20) showed that 43.5% of patients chose a specialist physician as an appropriate person to break the bad news, while a high percentage (20) showed that 88.5% of patients also chose a specialist physician as the appropriate person to break the bad news. When patients in the current study were asked who they preferred to disclose their condition they chose to be informed by the physician or a person skilled in breaking bad news. The majority of our patients confirmed that the physician gave them a warning shot that something bad would be told which made it easier to accept the news. In a study in Saudi Arabia (20), 54.4% of the patients preferred that the physician start with “Allah’s will, grace and remembrance” before breaking the bad news.

Three-quarters of our patients preferred to be accompanied by a family member while receiving bad news, which is similar to a study done in Germany (22), which showed that 76.5% of patients preferred to be accompanied by a relative or a loved one. On other hand a study done in Saudi Arabia (20) found that 61.2% of participants would rather not be accompanied by anyone while receiving the bad news, and lower result 56.15% of the patients found in the same study (20), were eager to be accompanied by someone while receiving bad news.

In the current study, nearly all of the patients preferred to be told step by step (in small parts) while breaking the bad news, similar to the findings of Karim et al (21), while Seifart et al (22) showed that 25% of patients preferred that all information are given to the patient at diagnosis.

The majority of our patients preferred that their physician knows how aware they are of their condition and to ask about their feelings before breaking the news which is higher than the result of Aminiahidashti et al study (19) who found that 66.9% of their patients also preferred the physician to know how aware they are about their condition.

In the current study, the patients preferred to consider their psychological status while breaking the bad news, which is lower than that reported by Aminiahidashti et al (19), which showed that 76.9% of patients preferred to consider their psychological status while breaking the bad news.

The current study showed that most of the patients preferred the physician to use the word “disease” instead of the word “cancer”. Seifart et al (22) found that 32% of Australian patients preferred the physician to use the word “disease” instead of the word “cancer”.

The current study found that the gender of the informer physician doesn’t affect the news, which is lower than that reported by Koch et al in the USA (23), who found that 90% of their patients did not mind the physician’s gender when breaking the bad news, A study conducted by Akalu et al in the UK (17) found no significant association.

The majority of patients in the current study did not mind the age of the informing physician, which is different from the study of Aminiahidashti et al in Iran (19), who found that 78.5% of their patients thought that an elderly doctor is a more suitable person to break bad news.

The present study showed that the majority of patients needed privacy while breaking bad news. Karim et al in Saudi (21) and Aminiahidashti et al in Iran (19) showed that 86.6% and 86.9% agreed. The findings of Alrukban et al in Saudi Arabia (20) found that both females and males preferred ensuring privacy and adequate time during receiving the bad news. Females in our society need privacy more than males. Just over one half of the patients (52.3%) in a study done in Germany (22) revealed that place and privacy are important in breaking bad news.

Nearly all patients in the current study needed adequate time, which is important in breaking bad news, but a lower result was found by Koch et al (23), with 84.5% of patients preferring that the physician give them adequate time, which is important in breaking bad news.

The current study showed that patients wanted to be completely aware of their illness, similar to the results found by Aminiahidashti et al (19), with 78.6% of patients saying that awareness of their medical condition positively influences continuing medical treatment.

The patients in the current study did not consider the availability of a psychiatric consultation necessary while breaking the bad news, while 61.5% of patients Aminiahidashti et al study (19) said that a psychiatric consultation is necessary at the time of breaking bad news.

The current study showed that the physician’s experience was thought to affect patient’s compliance during receiving bad news and that the physician should summarize and check their medical history to date, similar to the results of Aminiahidashti et al (19) which showed that 92.3% of patients thought physician skill in treatment affects the compliance of receiving bad news. This result is inconsistent with that of Parker et al in the USA (25), with 34.4% of patients wanting the physician to be skilled and confident.

The majority of patients in the current study felt that a cancer diagnosis is more difficult to receive than other diseases, which is in agreement with the results of Aminiahidashti et al (19), with 82.3% of the patients agreeing that receiving bad news about a common disease is much easier than hearing about a rare disease.

The patients in the current study agreed that it is better to train physicians and paramedical staff in communication skills and how to break bad news to patients with cancer, but a lower result (50.8%) was found by Aminiahidashti et al (19). This may indicate that paramedical staff may lack some communication skills regarding breaking bad news.
Breaking the bad news in a step-by-step approach is important to patients, especially older ones, which may be due to that older patients need more time to accept such a diagnosis and to understand everything about their disease, since most of them are responsible for families, and the diagnosis may change their lives. Young patients in the current study cared about the age and gender of the informing physician, which was not in agreement with the results of Akalu et al in the UK (17), where no difference was found. This may delineate some sort of gender discrimination in our community regarding physicians' gender and the misconception that physicians' age can affect breaking the bad news.
Gender had a significant role in the current study on patients' preferences regarding the need to be asked first about their feelings and to consider psychological status while breaking the bad news, which may be due to females being more sensitive and always needing support when something touches their feelings. The current study showed a significant difference in gender regarding being informed about the disease, treatment, prognosis, and life expectancy, as the majority of female patients agreed that is similar to the findings of Seifart et al (22) and Jenkins et al (24). Gender was found to have a significant role in the current study, unlike the findings of Alrukban et al in Saudi Arabia (20), where both females and males preferred ensuring privacy and adequate time during receiving the bad news; this is because females in our society need privacy more than males.
There was no significant difference in age and gender regarding the use of the word "disease" instead of the word "cancer" by the physician, because regardless of the age or gender, patients feel more comfortable when the physician names the cancer as a "disease".
The current study showed that patient's age had no significance regarding the disease, type, prognosis, treatment, and life expectancy, as the majority of patients preferred to be fully informed about their disease, which is similar to the findings of Aminiahidashti et al (19). Some studies found that in the Middle East older patients want to know as much as younger patients, but this was not the finding reported by Alrukban et al (20). Parker et al (25) and Akalu et al (17) found significant differences between age groups regarding their awareness o the disease, indicating a pronounced need in younger patients.

Limitation: A larger patient sample is difficult and palliative therapy during the study to ensure response accuracy

Conclusion:
Patients diagnosed with cancer are willing to learn about the diagnosis and keen to receive details as early as possible about their type and prognosis, treatment, and life expectancy. Issues like the physician's gender and age, privacy, adequate time, and staff communication skills are important and should always be considered.

Authors' declaration:
We confirm that all the Figures and Tables in the manuscript belong to the current study. Besides, the Figures and images, which do not belong to the current study, have been given permission for re-publication attached to the manuscript. Authors sign on ethical consideration's Approval-Ethical Clearance: The project was approved by the local ethical committee in (Place where the research was conducted or samples collected and treated) according to the code number **(…5859...) on (29/ 01/ 2017)**
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Authors' contributions:
Study conception & design: (Lamyaa A. Hasan & Manwar A. Al-Naqqash). Literature search: (Israa H. Nader). Data acquisition: (Israa H. Nader). Data analysis & interpretation: (Israa H. Nader). Manuscript preparation: (Israa H. Nader Manuscript editing & review: (Saad D. Tahir).

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تفضيلات المرضى في نقل الأخبار السيئة: دراسة مقطعية

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الخلاصة
الخلفية: إن التواصل الفعال بين الأطباء والمرضى يشكل قاعدة مهمة للغاية في عيادات السرطان والمرضى الخارجيين، أما الأخبار "السيئة" فهي أي معلومات من شأنها أن تغير بشكل جذري آفاق حياة المريض واحتمالاته المستقبلية. وتشمل هذه الأخبار الحقائق المتعلقة بالتشخيص والانتكاس وفشل العلاج في بيئات الأورام السريرية.
الهدف: تقييم اتجاهات مرضى السرطان نحو تلقي الأخبار السيئة عن حالتهم، وعلاقة بعض المتغيرات الاجتماعية والديموغرافية بهذه الاتجاهات.
المنهجية: أجريت دراسة مقطعية من 19 فبراير إلى 1 يونيو 2017 في مستشفى الأورام في مركز مدينة الطب التعليمي / بغداد. أكملت مجموعة من 212 حالة الاستبيان الذي تضمن معلومات اجتماعية وديموغرافية (العمر والجنس والحالة الاجتماعية والمهنة والتعليم). تم وضع أسئلة التفضيل والموقف كما هو موضح في الخطوات الموصى بها لبروتوكولSPIKES ، وهي طريقة مكونة من ستة أجزاء لمشاركة الأخبار السيئة مع المرضى (الإعداد والإدراك والدعوة والمعرفة والعواطف والملخص).
النتائج: تم تصنيف المرضى إلى فئتين عمريتين؛ أولئك الذين تبلغ أعمارهم 50 عامًا أو أكثر (64.2٪) وأولئك الذين تقل أعمارهم عن 50 عامًا (35.8٪). من بين 212 حالة (46.2٪) كانوا ربات بيوت و (20.8٪) كانوا موظفين حكوميين. فضل غالبية المرضى (80.2٪) أن يتم إعلامهم بمرضهم ونوعه وتوقعاته وعلاجه ومتوسط العمر المتوقع في الزيارة الأولى. اعتقد معظم المشاركين (67.9٪) أن الأطباء الأكثر خبرة ومهارة يجب أن يخطروهم بشكل كامل عن حالتهم الطبية. فضل غالبية المشاركين (81.1٪) أن يستخدم الطبيب كلمة (مرض) بدلاً من كلمة (سرطان). اعتقد معظم المرضى (75.5٪) أنه من الأفضل تدريب العاملين في الرعاية الصحية على مهارات الاتصال وكيفية إخبار الأخبار السيئة.
الإستنتاج: إن المرضى الذين تم تشخيص إصابتهم بالسرطان يرغبون في التعرف على التشخيص ويحرصون على تلقي التفاصيل في أقرب وقت ممكن حول نوع المرض وتوقعاته وعلاجه ومتوسط العمر المتوقع. إن قضايا مثل جنس الطبيب وعمره والخصوصية والوقت الكافي ومهارات التواصل عند الموظفين مهمة ويجب أخذها في الاعتبار دائمًا.
الكلمات المفتاحية: نقل الأخبار السيئة؛ السرطان؛ التواصل؛ بيئة الرعاية الصحية؛SPIKE