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Delivering bad news by physicians – Polish reality check

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ABSTRACT

Introduction. Disclosing unfavorable information is a very important moment in both diagnostic and therapeutic processes. It is also a highly stress-inducing factor, both among patients and physicians. During our research we tried to establish how exactly bad news is communicated to patients and the amount of stress that Polish physicians are under in such situations.

Material and Methods. Quantitative research was conducted in a university clinical hospital. With the use of an anonymous questionnaire, physicians (n = 100) from oncology, internal diseases, cardiac surgery, gynecology, obstetrics, and urology clinics were asked about the sources and the intensity of stress involved in BBN (Breaking Bad News). Similarly, patients (n = 378) of said clinics were asked to evaluate the relationships they had with their doctors.

Results. Most (66.7%) clinicians declared they always conveyed unfavorable information to their patients fully and in detail. Exactly 50.0% admitted they were experiencing high or very high level of stress while doing so. They were mostly (56.1%) anxious about depriving their patients of hope and (38.5%) feared they were letting their patients down. 37.3% of clinicians were afraid of emotional response. Significantly fewer physicians (43%) than patients (84.6%) were of the opinion that all of the medical orders must be followed to the letter.

Conclusions. Results suggest that BBN was a stressful experience for physicians. It was mostly related to the fear of disrupting the patient's well-being. Low level of effective communication was caused by the insufficiency of BBN skills. Social and cultural aspects also played a role.

Keywords: Clinical-Patient Communication, Doctor-Patient Relationship, Breaking Bad News.

Introduction

Breaking bad news is one of the hardest duties physicians must face during their professional practice [1]. As numerous studies have shown, the level of soft skills demonstrated by clinicians while disclosing unfavorable information is directly proportional to therapeutic results [2]. Proper communication has a substantial impact on the quality of medical influence, increasing the level of trust in doctor-patient relationship, among other things [3]. On one hand, not only is this communication essential in achieving the patient's full coopera-

tion during medical treatment and their involvement in the therapeutic process, it also improves the patient's psychological endurance. It results in faster recovery and/or less severe symptoms of the disease. On the other hand, the level of distress, including the intensity of pain and discomfort the patient is experiencing, increases with anxiety and stress-inducing circumstances, which are correlated to the feeling of being ill-informed or confused. The use of soft skills while breaking bad news serves another vital purpose, which is to protect physicians from excessive stress. The feeling of

duty well performed reinforces one's self-confidence as a professional and helps to prevent the risk of occupational burnout [4].

With our study we tried to establish how exactly bad news is delivered to patients and what amount of stress Polish physicians are under in such situations. What we wanted to find out was how doctors actually cope, seeing that their responsibility is not only the duty of care, but also to teach and socialize students and young physicians professionally. We were interested in the comparison of the physician and patient preferences in the context of mutual influence in the doctor-patient relationship. We concluded it was an important socio-cultural variable, which determines the method of disclosing medical information.

Material and Methods

The survey was conducted between February and June of 2015 in the University Clinical Centre in Gdansk. It is a clinical hospital functioning at the Medical University of Gdansk. It has been classified under the highest, third level of specialization. According to the Polish Ministry of Health standards, it is a model health, research and training facility.

The first group of respondents consisted of physicians ($n = 100$) from thirteen different clinics: oncology, internal diseases, cardiac surgery, gynecology, obstetrics, and urology. Adult patients of said clinics ($n = 378$), fully responsive and being prepared to leave the hospital when the survey was taking place, constituted the second group. The selection of both clinicians and patients meeting the above criteria was random (**Table 1**).

The data was collected with the help of a survey questionnaire created by an interdisciplinary team of experts specializing in clinical psychology, medical sociology and medical law. The research instrument contained questions about the sources and level of stress connected with the necessity of disclosing unfavorable prospects to patients as well as the evaluation and nature of the doctor-patient relationship. Statistica v.12 software was used for statistical analysis. The respondents' opinions and evaluations were compared with the demographic, health and medical variables. The analysis of the relationship between the discrete variables and the statistical heterogeneity of the respondent groups was made with the use of the Pearson's chi-square test. The differences were considered statistically significant if the $p < 0.05$.

Table 1. Characteristics of the Respondents

Doctors			Patients		
	n	% of n		n	% of n
Sex			Sex		
Women	52	53.6	Women	246	65.8
Men	42	46.4	Men	128	34.2
Age			Age		
≤ 30	23	23.0	18–30	46	12.3
31–40	42	42.0	31–40	55	14.7
41–50	25	25.0	41–50	65	17.4
51–60	10	10.0	51–60	63	16.8
			≥ 60	145	38.8
Academic degree			Marital status		
M.D.	55	60.4	Single	57	15.2
Ph.D.	29	31.9	Married	267	71.2
Sc.D.	7	7.7	Divorced	24	6.4
Specialty			Widow / Widower		
None	44	45.4		27	7.2
One	23	23.7	Education		
Two	28	28.9	Junior high school	3	0.8
Three and more	2	2.1	Vocational	91	24.6
Position			Secondary	119	32.2
Junior doctor	3	3.5	Higher	135	36.5
Resident doctor	31	36.5	Hospitalization time in a year		
Junior assistant	11	12.9	≤ 7 days	191	51.3
Senior assistant	38	44.7	8–14 days	93	25.0
Senior registrar	2	2.4	15–21 days	26	7.0
			≥ 22 days	62	16.7

Results

Ways of delivering bad news

We began our study with an attempt to determine the physicians' approach to breaking bad news (**Table 2**). Most of them declared they always inform their patients personally and in full detail about unfavorable medical diagnosis and/or prognosis (66.7%). More than every tenth clinician admitted they convey only carefully pre-selected information, which means their patients are not being fully informed about their clinical state. Exactly 58% of the doctors claimed they would be interested in a communication procedure, which could provide some effective methods of disclosing unfavorable news, were it available in Poland.

Levels of stress

A significant majority of the physicians recognized the moment of delivering bad news as extremely stressful, regardless of the way it was done (**Table 3**). More than half of the respondents declared intense stressor overload. Specialists described their experiences as highly stressful significantly more often than residents ($p = 0.03929$).

Sources of stress

According to the surveyed clinicians, the fear of depriving their patients of hope was the main (56.1%) cause of stress (**Table 4**). A substantial percentage (38%) of respondents admitted they felt uncomfortable knowing patients were expecting to

Table 2. Physicians' approach to breaking bad news

Categories of response	% of $n = 100$
I always inform my patients personally and in full detail	66.7
I do not inform my patients in hope they will figure it out themselves	0.0
I prefer to disclose unfavorable news only to the patient's family	1.0
My patients get information from the medical documentation they are given when leaving the hospital	1.0
I issue a referral for my patient to see a specialist, hoping the information will be given there	0.0
I convey only pre-selected information	12.1
I have other methods than mentioned above	19.2

Table 3. Declarative level of perceived stress

Level of stress*	$n = 92$	% of n
No stress	4	4.3
Very low and low level of stress	15	16.3
Moderate level of stress	25	27.2
High and very high level of stress	46	50.0
Maximum stress intensity	2	2.2

* The respondents were asked to indicate their answer on an 11-point scale, where 0 meant "no stress" and 10 meant "maximum stress intensity". The answers were categorized as follows: 0 = "no stress", 1-3 = "very low and low level of stress", 4-6 = "moderate level of stress", 7-9 = "high and very high level of stress", and 10 = "maximum stress intensity".

Table 4. Causes of stress involved in breaking bad news

Categories of response*	% of $n = 83$
Depriving the patient of hope	56.1
Patient's emotional response	37.3
Lack of sufficient training	9.6
Time limit	14.4
Prognostic uncertainty	15.7
Family members insisting on nondisclosure of unfavorable information	4.8
The feeling of inadequacy or hopelessness	12.0
A long-term relationship with the patient	4.8
Patient's expectations as to the positive outcome of treatment	38.5

* The respondents could pick only two of the answers.

hear good news about their treatment, and communicating unfavorable information would mean letting them down. Exactly 37.3% of the doctors disclosed they were afraid of emotional response. Almost every seventh respondent (15.7%) picked out prognostic uncertainty and the discomfort caused by insufficient amount of time they were able to offer their patients when delivering bad news (14.4%). Every tenth physician experienced the stress-inducing feeling of inadequacy and hopelessness while delivering unfavorable news. Only 9,6% of the clinicians recognized lack of training and the resulting skill deficiency in terms of communicating bad news as considerably stress-inducing.

Key aspects of the doctor-patient relationship

Clinical communication is substantially determined by cultural and social references. Thus, we asked doctors and patients for evaluation of the main components constituting the physician-patient relationship (Table 5). Majority of respondents from both groups declared they preferred partnership in the doctor-patient interaction. In their opinion, the patient should also have the right to participate in conscious decision-making concerning therapeutic choices. Most of the interviewees recognized the physician's obligation to inform the patient fully about their health. There was a considerable asymmetry as to the issue of following medical orders. A significant majority of patients (84.6%) believed they must follow all medical orders to the letter. Only 43% of the clinicians held the same view, while every fourth physician decided that their patients are not obliged to adhere to treatment recommendations.

Discussion

Numerous statistics show that delivering unfavorable information is a highly stressful task for physicians [1, 5–7]. As can be seen from the results of our survey, Polish doctors face the same problem. More than 52% of the clinicians admitted they felt intensely stressed while disclosing bad news (see Table 3). In our opinion, however, these results need to be interpreted with the socio-cultural aspect in mind. Even though it affects the doctor-patient relationship noticeably [8], it is rarely taken into consideration during research. We believe that the principle of autonomy, fundamental in the Anglo-Saxon countries, translates into how physicians understand their duty of delivering unfavorable information. Suitable preparation for this task, offered to future clinicians as part of medical education [9], notification protocols [10–12] and psychological support, are further elements of importance owing to their stress-reducing function.

Our study has shown that, in case of Polish doctors, basic stress-inducing categories connected to breaking bad news involve anxieties concerning the patient's well-being (fear of depriving the patient of hope or being unable to meet the patient's therapeutic expectations; see Table 4). Although the majority of both patients and clinicians have declared they prefer partnership in doctor-patient interactions, the percentage of neutral opinions has also been sizeable. As many as 40% of the surveyed patients expressed their negative view about the idea of physician-patient therapeutic partnership (see Table 5). The paternalistic model of practice seems to remain deeply rooted not only as a physicians' attitude but also as some patients' expectation.

Table 5. Comparison of respondents' preferences as to key aspects of the doctor-patient relationship

Evaluative statement		Disagree*	Neutral*	Agree*
		n (%)		
Patient and physician are partners in the therapeutic process	Doctors	6 (6.0)	39 (39.0)	55 (55.0)
	Patients	40 (11.6)	74 (21.4)	231 (67.0)
Patients must follow all medical orders to the letter	Doctors	25 (25.0)	32 (32.0)	43 (43.0)
	Patients	15 (4.3)	39 (11.1)	297 (84.6)
Patients have the right to participate in conscious decision-making about their own health	Doctors	2 (2.0)	10 (10.0)	88 (88.0)
	Patients	8 (2.3)	23 (6.6)	318 (91.1)
Physicians are obliged to disclose all information concerning the patient's health to the patient	Doctors	2 (2.0)	18 (18.0)	80 (80.0)
	Patients	8 (2.3)	15 (4.3)	329 (93.4)

* The respondents were asked to indicate their answer on a 6-point scale, where 1 "I strongly disagree" and 2 "I disagree" were put into the "Disagree" category, whereas 6 "I strongly agree" and 5 "I agree" were categorized as "I agree". Answers 3 and 4 were neutral and as such they were placed in the "Neutral" category.

The basic rule of the Polish medical model of ethics is the commitment to the priority of the patient's well-being. Any news which may disrupt it may not be delivered should the physician, in their subjective certainty, find its predictable consequences iatrogenic. Article 17 of the Polish Medical Code of Ethics includes the following guideline: "Information about diagnosis and unfavorable prognosis may not be disclosed to the patient only if the physician strongly believes that such disclosure will cause the patient great harm or affect the patient's health negatively in any other way; should the patient, however, explicitly demand otherwise, full information ought to be given". Put into practice, it means that clinicians with especially low level of soft skills and experiencing chronic stress tend to use the exception described in Article 17 to justify nondisclosure of information or to communicate only its pre-selected, shortened version.

The way bad news are delivered is another issue. High stress intensity is directly related to faulty clinical decision-making and results in premature closure [6]. Notification protocols may offer a satisfactory solution here. Unlike Anglo-Saxon countries, where these are considered standard, Polish educational system is not widely familiar with communication procedures of this kind [13]. As of today, basic communication skills shaping courses still have not found their place among regular academic modules offered to medical students in Poland. If they exist in any form, it is rudimentary and rather theoretical. Practical training of soft skills is hence available solely with the help of commercial courses organized outside of universities, i.e., hospices, private institutions, foundations, and associations. Over the course of the years merely two protocols have been created which may be considered useful in academic training and competence development. "The 5 Steps Method" is a procedure for communicating news about the death or a serious illness of a child to the parents [14]. „EMPATHY" is a protocol for disclosing unfavorable information to the parents of oncological patients [15]. No procedure has been established with adult patients in mind, even though almost six in ten clinicians would be interested in using it, as the results of our study have shown. It is true that clinical psychologists are being hired more and more often to assist doctors in breaking bad news. It is still not common practice, however. Furthermore, psychological services are provided exclusively to the patients. Formally, Polish physicians do not receive any support when coping with difficult clinical situations.

Those key factors seem to contribute to the low quality of clinical communication in general. In consequence, Polish doctors have ranked the lowest among all of the 18 countries participating in OECD research [16] in all of the categories, (1) "Spending enough time with patient" maximum: Belgium 97.5, OECD18 84.9, USA 80.9, minimum: Poland 69.6; (2) "Easy-to-understand explanations" maximum: Belgium 97.8, OECD18 87.9, USA 86.3, Poland 69.6; (3) "Giving opportunity to ask questions or raise concerns" maximum: Belgium 97.7, OECD18 85.0, USA 86.7, minimum: Poland 33.6; (4) "Involving patient in decisions about care and treatment" maximum: Luxembourg 95.4, OECD18 81.3, USA 83.9, minimum: Poland 47.9. It should be emphasized that, according to the OECD report, Poland holds third place in regard to the number of consultations provided by doctors per person per year. The organization of the health care system also seems to be an important variable, as it limits clinicians with excessive bureaucracy, hence reducing their time for direct contact with patients.

Through this study a number of issues emerged surrounding contraceptive method decision-making that could inform development of messaging and policy changes. First, communication campaigns could work to de-mystify the process that health 15 professionals use to support contraceptive decision-making. Communication campaigns should also help clients understand their important role in method choice by increasing their internal locus of control about contraceptive method decision-making. These campaigns would work best if done in tandem with training among contraceptive providers on client-centered counseling, including the important role of clients in the selection of the contraceptive method. Second, given how important switching contraceptive methods is in response to unmanageable side effects, contraceptive providers should be trained to discuss the strategy of switching to all clients – potential future clients, new clients, and continuing clients. Third, all persons who provide contraceptive methods, including those in the private sector, would benefit from training on client-centered counseling, especially related to counseling all clients – new and returning – on potential side effects. Widely disseminating accurate information about the importance of individual preference in contraceptive method choice, and the ability to switch methods, could increase contraceptive use in Nigeria through increased use among non-users, satisfaction with use among current users, and the power that comes from feeling in control.

As our study has shown, BBN was an intensely stressful experience for Polish physicians. This can be largely attributed to the fear of BBN disrupting the patient's well-being. Low level of soft competencies is, in our opinion, only one of the reasons for such an attitude. It has also a lot to do with paternalism, still present in some form and visible in the patients' expectations. Thus, we suggest that physician-targeted educational content should include notification protocols for BBN as part of soft skills shaping training programs. Even if the aforementioned tools (e.g. SPIKES protocol), which are created in Anglo-Saxon countries, happen to be less applicable for the other European patients [17], we do believe the above suggestion is valid, considering the low quality indicators of clinical communication in Poland. System solutions, such as communication skills training courses and psychological assistance for physicians experiencing extreme stress, also require due support.

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Conflict of interest statement

The authors declare no conflict of interest.

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Informed consent and ethical approval

Informed consent was obtained from all individual participants included in the study. The research was positively evaluated and approved by the Independent Bioethics Commission for Research at the Medical University of Gdansk.

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