

ST. PAUL'S HOSPITAL MILLENNIUM MEDICAL
COLLEGE

A CROSS-SECTIONAL STUDY ON PERSPECTIVES OF
PROTOCOL BASED BREAKING BAD NEWS AMONG MEDICAL
PATIENTS AND PHYSICIANS AT ST. PAUL'S HOSPITAL
MILLENNIUM MEDICAL COLLEGE



BY: HENOK FISSEHA, INTERNAL MEDICINE RESIDENT

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ST. PAUL'S HOSPITAL MILLENNIUM MEDICAL COLLEGE

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List of acronyms and Abbreviations

ASCO - American Society of Clinical Oncology

CKD – Chronic Kidney Disease

CLD – Chronic Liver Disease

HIV – Human Immunodeficiency Virus

HMIS - Health Management Information System

SPIKES – Setting, Perception, Invitation, Knowledge, Emotions, Strategy & Summary

SPHMMC - St. Paul’s Hospital Millennium Medical College

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Abstract

Background: *Discussing potential bad outcomes is a common communication task in clinical care and patient satisfaction with care and compliance with treatment is dependent upon it. Awareness of physicians on ways how to communicate bad news is considered low, which may occur due to lack of proper training. SPIKES protocol is the most popular and practiced strategy used by physicians but its practice and patients' perception is not known.*

Methods: *A hospital based descriptive cross-sectional study was conducted at SPHMMC from May 1 to June 30 by using a structured interview administered to patients and physicians. 360 patients and 111 physicians were included, assessment of SPIKES protocol implementation, patient satisfaction, patient preference, physician awareness, and attitude was done.*

Results: *Performance of SPIKES protocol was higher for Setting (74.5%), Perception (51.1%) and Invitation (56.3%) and low for Knowledge (15.9%), Emotion (22.3%) and Summary (10.1%). Only 30.6% of the patients were entirely satisfied with the interaction and 19.2% were entirely satisfied with the knowledge they attained. Satisfaction showed significant association with physician asking how much information they would like to be given ($P=0.025$). Comparison of patient desire and actual report of performance showed significant variation. 82.1% of the physicians were not aware of the protocol and 83.8% have not had any training. Knowledge was the easiest and setting the most difficult for physicians. Physicians face adverse effects with half feeling depressed after disclosure.*

Conclusions: *Patient satisfaction with communication process and knowledge is poor and so is performance of SPIKES protocol components. Satisfaction is related to being asked how much patients want to know. Patient's desires on how to be told their news is very different from how it is actually done. Breaking bad news increases feeling of being depressed in physicians. Awareness and training on the protocol is very low and medical schools should incorporate it into their studies and implement proper follow-up.*

Chapter I: Introduction

1.1. Background

Discussing serious news, or breaking “bad news” is a common communication task in clinical care. Virtually every clinical specialty requires doctors at some stage to be the bearers of sad, bad, or difficult news [1]. “Bad news” has been defined as “any information likely to alter drastically a patient’s view of his or her future...” [2].

If it is not communicated in the right way, it can result in impaired emotional response on patients as well as, excess stress, negative attitudes toward the treating staff, miscommunication and poor physical outcome [1, 3, 4, 5, 6]. Studies have shown that patients are at times not satisfied with ways physicians communicate such kinds of news [3, 4].

One of the most popular and accepted strategies to break bad news worldwide is the SPIKES (Setting up, Perception, Invitation, Knowledge, Emotions, Strategy & Summary) protocol published in 2000 by Walter F. Baile. It has gained immense popularity, is used in all range of doctor and physician communications, in western countries has achieved guideline status, and is incorporated in many curriculums as part of communication skills training [7, 8]. The name is the acronym describing the consecutive steps of a conversation, each of which is necessary for proper and satisfactory communication. Starting with S (Setting up), the process of preparing for the talk, through P (Perception), and I (Invitation)—the parts in which the physician determines the patient's perception of the situation and readiness to receive the news and which precede the information breakout, described in the next component—K (Knowledge). Then E (Emotions) follows, being the proper way of responding to patient’s emotions. Eventually, S (Strategy & Summary) will follow [3, 8, 7].

This study will determine the level of implementation of the protocol, satisfaction with communicating bad news to medical patients, and their preference; assess current knowledge, attitude and effect on physicians, and help recommend ways to improve them. To the researcher’s knowledge this will be the first study done on this topic on medical patients in Ethiopia and will have important implications including improving patient care and satisfaction and increase physicians’ awareness and practice of the protocol and will serve as an evidence based input to improving medical curriculum design.

1.2. Statement of the problem

Discussing bad news is a common task of physicians in routine care. It is considered to be primarily a challenge to oncologists who deal with patients with cancers of different types but patients in internal medicine also suffer from a great deal of ailments including incurable chronic illnesses like HIV, diabetes, chronic kidney and liver diseases to mention just a few. Doctors are confronted with the responsibility of communicating diagnosis, recurrence and prognosis of a disease. They need to relay information such as treatment failure, development of side effects, lack of any further meaningful treatments and loss of patients' loved ones. These are conditions occurring every day during routine clinical practice and it turns the question of whether physicians working in internal medicine deliver bad news to how frequently they do it [1, 6, 10, 11].

Bad medical news is life altering and distressing to patients in its nature and hence needs extra compassion and care during its delivery. Good communication skills are important aspects of patient physician interaction. They have been shown to improve pain control, adherence to medications, help build trusting relationship, enhance physical outcomes and as a whole increase the level of satisfaction with care. On the contrary if not conveyed in the right way there can be adverse consequences to the patient including excess stress and anxiety, negative attitudes towards the treating staff, poor treatment compliance and cooperation, miscommunication and resentment of the treating staff and dissatisfaction with healthcare. Negative disease related physical outcome has also been related to poor physician patient communication. It can lead physicians to have anxiety, feeling of guilt, dissatisfaction with work and interfere with the communication process with patients [1, 3, 4, 5, 6, 25, 26].

Despite the important positive impacts having good communication skills has on patients and physicians there is a widespread problem with physicians' skills as well as knowledge on the standardized ways of conveying bad news. Studies have shown that there are improvements that need to be made with regard to the knowledge, attitude, skill and practice of using SPIKES protocol. Other challenges arise when physicians become unable to control their own emotions, ask and recognize patients' desires, and to show empathy. There is also a lack in finding appropriate place and time. SPIKES is not included in teaching curriculums and not included as a guideline for patient care in Ethiopia [3, 15, 16].

Data regarding the utilization of such kinds of protocols and patient satisfaction on medical patients has not been studied in Ethiopia and in developing countries as a whole.

1.3. Significance of the study

Knowing patient satisfaction and preferences will help create evidence based awareness on the patient centered communication style that needs to be followed and improve patients' satisfaction with care. This will help to narrow the communication gap between the two parties, create a smooth interaction, improve adherence to healthcare and improve the quality of care provided as a whole.

It will help to identify the specific components of the SPIKES protocol where significant underperformance is seen by both patients and physicians and recommend ways to improve them. It can also recommend modifications to the protocol that can be applied in the local setting. It will help to bring to the front the challenges faced by physicians and help recommend ways to avert them.

It will create awareness by health care providers, educators and policy makers on the need for a formal training on the subject and will help incorporate SPIKES protocol to both undergraduate and postgraduate training curriculums as training will increase its utilization. It will assist during hospital designs by creating awareness on the need for private rooms for patient counseling.

Chapter II: Literature review

Bad news and SPIKES protocol

Discussing serious news, or breaking “bad news” is a common communication task in clinical care. Virtually every clinical specialty requires doctors at some stage to be the bearers of bad or difficult news [1].

“Bad news” has been defined by the world renowned oncologist Robert Buckman as “any information likely to alter drastically a patient’s view of his or her future...” or that “...results in a cognitive, behavioral, or emotional deficit in the person receiving the news that persists for some time after the news is received” [1, 9]. In the context of medicine, some examples of bad news situations include disease diagnosis, disease recurrence, failure of treatment, prognostication of outcomes, presence of side-effects of treatment, results of genetic tests, ineligibility for a clinical trial, more recently disclosure of medical errors, raising the issue of palliative care and resuscitation [2, 6, 8].

How an individual gives significance to unfavorable information strongly depends on the receiver’s perception, expectations, personal experience, how sick they actually feel, preexisting suspicion of the underlying illness and psychosocial factors [2, 3].

Studies have shown that that good, patient-centered communication is associated with many important and meaningful health outcomes, including adherence to drug regimens, pain control, patient satisfaction, improved emotional health, better symptom resolution, improved functional and physiologic status, trust in the physician, and physical health outcomes [1, 26].

Performed improperly, it can lead to patient’s emotional breakdown with undesired stress and anxiety; difficulty with adjustment and coping; loss of fighting spirit; negative impact on beliefs and attitudes toward the medical staff with reduced compliance and further cooperation; as well as miscommunication and misunderstanding of the prognosis of the illness or purpose of care. It can also affect how patients view their future, create feelings of hostility and resentment towards the carrier of bad news; culminating in an increased complaint about physicians and risk of litigation as well. There are evidences suggesting there will be lack of satisfaction with care and even reduced physical health outcome [1, 3, 4, 5, 6, 25].

During the last decades, a range of guidelines or models have been developed that serve as a framework for communicating serious news. The most popular guideline, the SPIKES protocol recommends a six-step protocol for delivering bad news, with a special application for cancer patients [2]. It was evaluated for structuring the delivery of bad news in the United States and it had reached guideline status in America and in a number of other countries and has shown to positively affect outcomes [8]. It is used as a guide for communication skills training and delivery of bad news and medical error reporting [1, 4, 8]. Since then, there have been several other models created, including ABCDE (Advance, Build, Communicate, Deal, Encourage) and GUIDE (Get, Understand, Inform, Deepen, Equip), and BREAKS (Background, Rapport, Explore, Announce, Kindling, Summarize) [1].

The SPIKES protocol has been used on patients and physicians in fields other than oncology including patients with HIV, patients on chronic dialysis, spinal cord injury, and physicians working in almost all fields [10, 11, 12, 13, 14, 15, 16].

Knowledge and practice of the protocol

According to the results of a survey of Breaking Bad News Symposium done by American Society of Clinical Oncology (ASCO), 1998 showed less than 10% of survey respondents had any formal training in breaking bad news and only 32% had the opportunity during training to regularly observe interviews where bad news was delivered [7]. In two different studies done on south Korean and Canadian physicians have shown that level of training was less than desired with 63 to 70 percent having received any form of training [14, 17]. The situation regarding training is far from satisfactory in most of the developing countries. Different surveys conducted on physicians and medical schools in Iran, Turkey, India, Pakistan showed lack of training in communication skills at the undergraduate and postgraduate levels [16].

There are different studies assessing the practice of SPIKES protocol. According to the ASCO survey 95.4 percent of responders said the protocol is practical and can be used in clinical practice. In a 2013 Korean study on residents and fellows in one teaching hospital, 80% of trainees said that they followed the SPIKES protocol [7, 14]. On the contrary, in one study none of the participating physicians were aware of any protocol but when further questioned they practiced specific components of the SPIKES protocol to some extent despite their lack of awareness. For instance, around 78 % prepared adequate setting, more than 90 % set adequate time and similar number

respected patients demands. At the end almost half recommended for there to be a formal training. Another study showed highest compliance with the protocol was setting up, knowledge and emotions (70-75%) and the lowest was with perception, invitation and summary (27-56%). This shows the great importance of using specific protocols and training health care providers on them [3, 15].

Physician attitude, perception and effect on physicians

At present, clinicians generally believe that patients should be informed of their diagnoses. However, clinicians generally prefer not to disclose all of the available information [1, 17]. Factors that influence clinicians' behavior include lack of control (over time or setting), feelings of failure or inadequacy, fear of the patient's as well as one's own emotions, lack of knowledge to answer anticipated questions, personal fear of illness and death, work related burnout and fatigue, deficiency of experience, spiritual and cultural believes, geography, personal attitudes, fear of harming the patient and fear of being blamed [1, 2, 17, 22, 23]. The participants in the ASCO survey identified several additional stresses in giving bad news with "how to be honest with the patient and not destroy hope" as most important, followed by "dealing with the patient's emotions" and the least mentioned factor "finding the right amount of time" [7].

Communicating serious news can also negatively impact the clinician. Multiple clinician surveys demonstrate that clinicians find discussing serious news stressful. Many doctors have difficulty handling their own emotions and other negative attributes of giving such news include feeling of sorrow, guilt, identification, and feeling like a failure, excess feeling of burnout, job dissatisfaction, and poor patient physician rapport. Moreover, it can be a leading cause of litigation against the doctor and health facility [1, 17, 20].

Patient satisfaction and perception

Most patients prefer to be informed of their diagnoses, with studies demonstrating this preference in more than 95 percent of patients [1, 21]. However, there is some variation in what specific types of information patients want to know, with a variable and lower percentage wanting to know their specific prognosis and wish to be involved in end of life discussions [1]. Majority of patients want to be informed themselves first with discrepancy in the number of patients who want family members to be around [21, 22].

Patient satisfaction is by far the most recognized, easy, widely used, albeit indirect measure for evaluating the effectiveness of physician-patient communication [25].

In general, satisfaction with physician–patient communication is known to depend on different factors, including communication skills and style of the physician, physician–patient relationship as well as biomedical and psychosocial factors [4]. A brazil study evaluated the satisfaction with knowledge attained after breaking bad news and only around 56 percent were satisfied [3]. Another study had similar conclusions with only 46% of the patients being entirely satisfied with the communication process [4].

Chapter III: Objectives

3.1. General objectives

To assess the implementation of SPIKES protocol to patients in internal medicine department at SPHMMC when delivering bad news, patient preference, and associated satisfaction; determine physician knowledge, attitude and its effects.

3.2. Specific objectives

To measure the level of implementation of SPIKES protocol

To measure patient preference when bad news is communicated

To determine the level of patient satisfaction with physicians' delivery of bad news

To determine the knowledge of physicians on SPIKES protocol

To determine the attitude of physicians on SPIKES protocol

To determine the untoward effect the process of breaking bad news has on physicians

Chapter IV: Materials and methods

4.1. Study area and study period

The study was conducted in St. Paul's Hospital Millennium Medical College (SPHMMC) located in Addis Ababa, Ethiopia. SPHMMC is a referral and teaching hospital established in 2007 after a medical college was opened in a Hospital built by Emperor Haile Selassie I in 1969 with the help of the German Evangelical Church aiming to serve the poor. It has a catchment population of more than 5 million [23].

According to the most recent data registered on the Health Management Information System (HMIS), there were a total of 625 patients admitted to the medical ward between January to June of 2018 with an average admission of 104 patients per month. Similarly, according to the HMIS taking average of the 6 months, 6,820 patients are expected to be seen in the referral clinics of the department including hematology, gastro-enterology, nephrology, cardiology, pulmonology, neurology, endocrinology and HIV clinics.

There are 37 seniors, 85 residents, 11 general practitioners and 23 interns expected to be working at the department during the data collection period.

The patients admitted to medical ward or following in outpatient clinics between May 1 to June 30 2019 with a diagnosis fitting the criteria of bad news as well as all physicians working in internal medicine department of the college served as the target population.

4.2. Study design

A descriptive cross-sectional study was conducted.

4.3. Source population and study population

The source population were medical patients who received a perceived bad news on a terminal, distressing or incurable diagnosis and all physicians working in internal medicine department.

Study population included patients admitted to medical ward and patients visiting outpatient clinics in the specified period who received a perceived bad news about a disease and physicians working in the wards during the time of interview.

4.4. Sample size and sampling method

The sample size was calculated using single population proportion formula. The total number of patients expected to be admitted in the study period is 208 and 6,820 patients are expected to be

seen in the referral clinics of the department including hematology, gastro-enterology, nephrology, cardiology, pulmonology, neurology, endocrinology and HIV clinics as published from HMIS report resulting in total population N of 7028. The value of P was taken as 50 percent since the implementation of SPIKES protocol is not known. Desired confidence level of 95% and margin of error of 5% was used. Final sample size of 364 patients was obtained. A convenience sampling method was used and all patients fulfilling the inclusion criteria were included until required sample size was met.

Among the 156 physicians working in the department, using similar formula 111 physicians were included and stratified as 26 seniors, 61 residents, 8 general practitioners and 16 interns selected using convenience sampling.

4.5. Variables

4.5.1 Dependent variable

Level of patient satisfaction with delivery of bad news by physicians.

Level of implementation of SPIKES protocol by physicians.

Level of knowledge of SPIKES protocol by physicians.

Attitude of physicians to about SPIKES protocol

4.5.2. Independent variable

The independent variables related to patients include sociodemographic variables including age, gender, education level and marital status while physician related ones include age, gender, marital status, job title and duration of graduation.

The other independent variables include the specific diagnosis and its duration, readiness assessment of patients, use of understandable language, adequacy of time provided, level of empathy, previous training, comfort in dealing with patient's emotions, physician emotions after breaking bad news, and fears about giving bad news.

4.6. Data collection method and tool

Data gathered was primary data obtained by administering a structured interview to patients. It was prepared by reviewing different literatures and undertaking modifications for the population studied. It was modified further after a pre-test was done before the data collection. The

questionnaire was prepared in English and translated to local language (Amharic or Oromiffa) during the patient interview.

It consisted of 47 questions divided in to four parts. First part contains the sociodemographic variables of patients including age, gender, education level, marital status, duration of diagnosis and the specific diagnosis. Second part was designed to evaluate the actual procedure of breaking bad news followed by patients' desire and finally level of satisfaction.

A self-administered questionnaire containing 32 questions was provided to the physicians participating in the study. It had five parts. First part assesses the sociodemographic status including age, gender, marital status, job title and duration of graduation. Subsequent sections had questions to evaluate the knowledge, practice, attitude and effect on physicians which was also subjected to a pre-test before the formal data collection.

4.7. Inclusion and exclusion criteria

4.7.1. Inclusion criteria

The inclusion criteria included all patients aged 18 years and above who consented to take part in the study and have received a perceived bad news including the mentioned diagnoses below by a physician in the last 1 year. It was planned to include patients in referral clinics and wards with diagnosis including Human Immunodeficiency Virus infection (HIV), chronic kidney disease, patients on chronic dialysis, chronic liver disease, heart failure, diabetes, malignancy, advanced dementia, chronic obstructive pulmonary disease and additional disabling conditions including stroke, Parkinson's disease, asthma, epilepsy and hemophilia.

Physicians working in internal medicine ward at the hospital during the time of data collection and who are willing to be part of the study were included.

4.7.2. Exclusion criteria

Patients who are too ill or weak to respond, and patients with mental disorders precluding the interview were excluded from the study.

4.8. Operational definitions

The following operational definitions were used in the study.

Bad news: any information related to a patient's illness likely to alter drastically a patient's view of his or her future [2].

Patient satisfaction: patients' opinion related to their desire and expectation. Patients will be considered satisfied if they select "entirely satisfied" on the questionnaire [24].

Entirely satisfied: above one's expectation [24].

Satisfied: satisfied, attaining one's expectation [24].

Dissatisfied: below expectation and desire [24].

Strongly dissatisfied: below one's expectation usually leading to disappointment [24].

4.9. Data quality control

Data was collected by the researcher and data collectors. The data collectors were trained about the contents of the interview and to collect the data in a compassionate and accurate manner. Immediately after administration of the questionnaires, each paper was checked for completeness. It was checked again during and after feeding of data.

4.10. Method of statistical analysis

Different statistical analysis methods were used ranging from frequency count of each variable to estimation of relative frequency, cross-tabulation between variables and descriptive statistical tests including estimation of mean and Wilcoxon signed-rank test. Paragraphs, tables, graphs, charts were used to illustrate findings. Moreover, Determination of statistical significance using chi-square test was applied using statistical package for social sciences version 25. In this study, all tests with $P\text{-Value} < 0.05$ were considered statistically significant.

4.11. Ethical consideration

Before conducting the research permission was obtained from SPHMMC research office and research ethics committee. Informed written consent was obtained from each participant after careful clarification of the aim and significance of the study. Every participant was given chance to deliberate on their rights to participate, refuse, or withdraw at any time they wish to do so. To ensure confidentiality, the name of respondents was not written in the questionnaires.

4.12. Dissemination of results

At the end of the research the findings will be distributed to the health care providers, hospital quality control bodies, administrators, policy makers directly affected by the results by publishing the results in a journal and making presentations on a research symposium.

Chapter V: Results and Discussion

5.1. Results

Patients

Out of the 374 questionnaires filled 14 were lacking critical information and not included in the study. From the interviewed patients majority (87.8%) were from outpatient clinic and the rest from medical ward. Male responders dominated by 59.2%. The youngest age was 18, oldest was 82 with mean age of 46.8 with 30.8% belonging to the 40-49 years age group. 75.6% were married and 27.3% did not have any formal education. 16.9% were unemployed and 59% live in an urban area as shown in Table 1 below.

Table 1: Sociodemographic characteristics of patients, SPHMMC, Addis Ababa, 2019

Characteristics	Number	Percent
Site		
Outpatient	316	87.8
Ward	44	12.2
Age Group		
18-29	36	10.0
30-39	70	19.4
40-49	111	30.8
50-59	71	19.7
>60	72	20.0
Gender		
Male	203	59.2
Female	140	40.8
Total	343	100.0
Marital status		
Married	260	75.6
Widowed	31	9.0
Divorced	20	5.8
Single	33	9.6
Total	344	100.0
Education level		
Illiterate	98	27.3
Primary school	52	14.5
Secondary school	69	19.2
Certificate or higher	140	39.0
Total	359	100.0

Occupation		
Government employee	121	34.1
Farmer	53	14.9
Private employment	57	16.1
Student	11	3.1
Unemployed	60	16.9
Other	53	14.9
Total	355	100.0
Residence		
Urban	207	59.0
Rural	144	41.0
Total	351	100.0

The most frequently identified diagnosis that patients had was CKD 62 (17.2%) followed by heart failure 58 (16%) different malignancies 47 (13.1%), CLD and Diabetes each 36 (10%). Many diseases affecting multiple systems were also included. Forty-seven patients with different malignancies were identified including diseases treated in internal medicine department like hematologic malignancies or advanced hepatocellular carcinoma or diseases treated and followed at oncology unit but had medical comorbidities like deep venous thrombosis, anemia or electrolyte disturbances that were having follow-up in the department. The majority (40.8%) had their disease disclosed at SPHMMC, followed by another hospital (37.7%), health center (14.8%) and private clinic (6.7%). Concerning time of disclosure, 38.2% were disclosed in the last three months while 20.9% in 3 to 6 months and 40.9% in 6 to 12 months. 58.7% heard the news in an office while 40.2% were informed in a patient's room. The tables 2 and 3 below will show this in further detail.

Table 2: *Diagnosis of patients, SPHMMC, Addis Ababa, 2019*

Diagnosis	Frequency	Percent
Asthma	15	4.17
Chronic Kidney Disease	62	17.2
Chronic Liver Disease	36	10
Chronic Obstructive Pulmonary Disease	14	3.89
Stroke	23	6.39
Diabetes	36	10
Epilepsy	4	1.11
Heart failure	58	16.1
HIV	47	13.1
Hypertension	2	0.56
Inflammatory Bowel Disease	4	1.11
Interstitial Lung Disease	1	0.28
Parkinson's Disease	1	0.28
Rheumatoid Arthritis	1	0.28
Systemic Lupus Erythematosus	9	2.5
Malignancy	47	13.1
Total	360	100

Table 3: *Malignancies identified among patients, SPHMMC, Addis Ababa, 2019*

Malignancy	Frequency	Percent
Cervical Cancer	6	12.8
Chronic Lymphocytic Leukemia	2	4.26
Chronic Myeloid Leukemia	3	6.38
Colorectal Cancer	3	6.38
Gastric Cancer	5	10.6
Hepatocellular Carcinoma	3	6.38
Leukemia	3	6.38
Lung cancer	5	10.6
Non-Hodkin Lymphoma	3	6.38
Osteosarcoma	1	2.13
Ovarian cancer	11	23.4
Pancreatic cancer	1	2.13
Renal Cell Carcinoma	1	2.13
Total	47	100

Some of the questions were provided as a yes or no question while most were given in an ordinal scale (from entirely satisfied to very much, somewhat or not at all satisfied) and entirely satisfied was the answer used in the analysis.

Level of implementation of SPIKES protocol

The level of performance of SPIKES protocol was evaluated by calculating the percentage of the average of the sum of response to specific questions. The highest response for ‘entirely done’ was with the first part of SPIKES-S with mean percentage of 74.5% and the least score was for S – Summary (10.1%). Setting - was assessed by 4 questions that addressed if patients were provided separate room for the interview (59.5%), if they were asked if they would like someone from their family (55.8%), whether the doctor was sitting down (88.6%) and maintained eye contact (94.2%) giving an average score of 74.5%. P – was assessed by whether patients were asked how much they had actually known which was asked 51.1% of the time. I – two questions were used that included if the physician asked if the patient was ready (64.4%) and if how much information the patient wants was asked (48.3%) giving an average of 56.3%. K – part used 5 questions including how much they felt the physician prepared them mentally (14.7%), used understandable language (21.4%), gave adequate time (18.7%), clearly explain the information (13.6%), and discussed life expectancy (11.4%) with mean of 15.9%. E – was assessed by asking the emotional support and compassion of the physician and was entirely satisfactory in 22.3%. Finally S – summary part was also asked with a single question asking if the physician summarized the discussed and planned for a future which showed 10.1% entirely done. The table 4 and figure 1 below show the detailed questions and the answers given by patients.

Thirty nine (10.8%) of the patients were offered another conversation of which 41.6% were offered to talk to a priest, 38.8% another person and 19.4 to a psychologist.

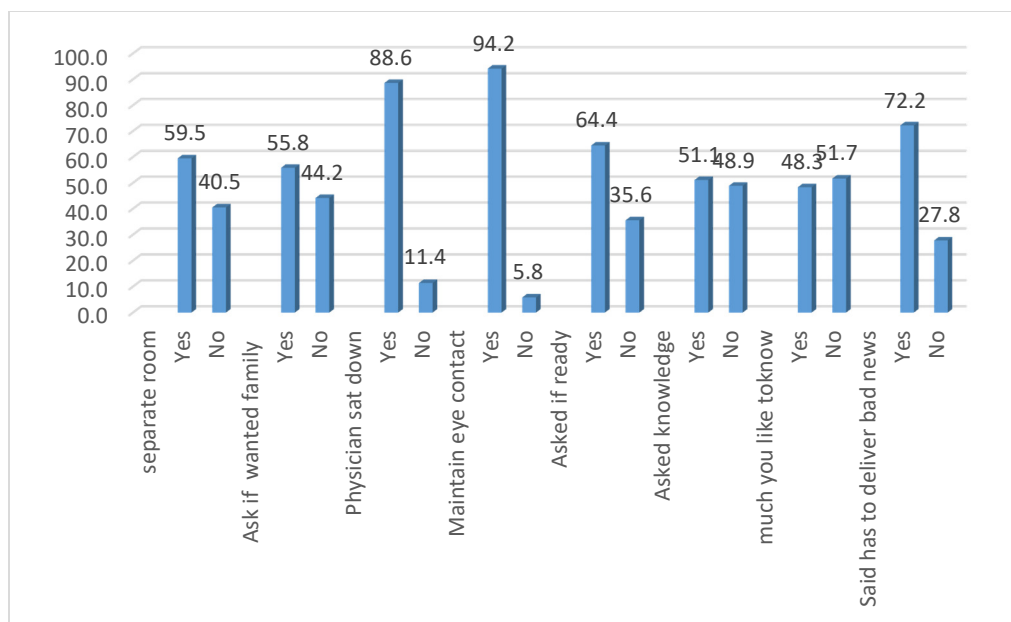


Figure 1: Percentage of answers to SPIKES performance questions, part 1

Table 4: Percentage of answers to SPIKES performance questions, part 2, SPHMMC, Addis Ababa, 2019

Question	Entirely	Very much	Somewhat	Not at all
Prepare mentally	14.7	45.8	33.6	5.8
Understandable language	21.4	45.6	31.9	1.1
Adequate time	18.7	49.3	30.9	1.1
Emotionally supported	22.3	53.6	22.6	1.4
Able to ask questions	26.2	40.7	30.5	2.6
Explain information	13.6	37	46.5	2.8
Life expectancy	11.4	41.4	38.3	8.9
Planned/Summarized	10.1	30.4	53.6	5.9
Intimacy	22	51	25.1	1.9

Emotional responses experienced were asked with 5 questions. Only 11.1% of patients responded that they became entirely sad and only 2.5% became angry. Only 18.4% said they became less anxious after talking with their physicians.

Table 5: Emotional response of patients, SPHMMC, Addis Ababa, 2019

Question	Entirely	Very much	Somewhat	Not at all
Became sad	11.1	25.3	32.5	31.1
Became angry	2.5	14.4	22.8	60.3
Became disparate	9.2	33.6	33.6	23.6
Trust doctor's advice	23.2	56.1	19	1.7
Less anxious	18.4	41.5	30.1	10

Patient Preferences

Patients' preferences were assessed by asking them to provide suggestions on how doctors can improve breaking bad news and components of SPIKES protocol were asked in 12 questions answered in a 4 part likert scale. The answers are provided in table 6 below but the highest response for 'entirely agree' was given for 'physician should check if the message was understood', 'should use simple and clear language' and 'should give warning' with response rates of 62.5%, 61.9% and 61.4%. Only 13.3 of patients responded that physicians should have the same sex as the patient and 42.8% entirely agree that physicians should show empathy during communication process.

Table 6: Patient preferences when disclosing bad news, SPHMMC, Addis Ababa, 2019

Question	strongly disagree	Somewhat disagree	very agree	much	Entirely/strongly agree
Warn me earlier	2.8	.3	35.6		61.4
Be simple and clear	1.4		36.7		61.9
Check if understood	1.7	.6	35.3		62.5
Ask questions	1.7	.3	38.6		59.4
Summarize and plan	3.1	.3	43.9		52.8
Should ask to bring family	5.6	.6	46.1		47.8
Give explanation	7.2	.6	44.7		47.5
Know outcome and prognosis	2.2	.6	43.7		53.5
Same sex	72.5	3.1	11.1		13.3
Undisturbed atmosphere	1.7	1.9	50.0		46.4
Enough time	.8	1.1	50.3		47.8
Empathic	5.6	5.3	46.4		42.8

Patient satisfaction

Patient satisfaction was determined in two ways. The first was by asking them to grade their satisfaction with their knowledge about the disease and its further management and with the overall interaction with the physician while bad news was broken to them. Only 19.2% were entirely satisfied when asked the first question and 30.6% for the second question.

Table 7: Patient satisfaction with communication of bad news, SPHMMC, Addis Ababa, 2019

	Frequency	Percent
Satisfaction with knowledge		
Entirely satisfied	69	19.2
Very much satisfied	174	48.5
Somewhat dissatisfied	100	27.9
Not at all satisfied	16	4.5
Total	359	100.0
General satisfaction		
Entirely satisfied	110	30.6
Very much satisfied	182	50.7
Somewhat dissatisfied	58	16.2
Not at all satisfied	9	2.5
Total	359	100.0

Chi square test for all sociodemographic variables, diagnosis, whether news delivered at SPHMMC or other places, office or in patient room, having separate place to deliver news, physician sitting down or not, maintaining eye contact and the level of intimacy patients described had no statistical relation with patient satisfaction or satisfaction with knowledge.

In the same manner patients who said their doctors prepared them mentally, used understandable language, adequate time, emotional support, physician explanation, being told life expectancy, patient emotions like being sad, angry or desperate, did not show any correlation. Patients' emotional response also did not show significant correlation with how bad news was delivered. When the 'entirely satisfied' response was analyzed it showed significant association with whether patients were asked how much information they would like to be given ($P=0.025$).

Comparison of patient desire and actual report of performance was done using Wilcoxon signed-rank test and illustrated in table 7. Out of the assessed 10 questions only 'physicians should ask if

patients want a family or friend present' was not statistically different. The strongest differences were seen with 'should use simple and clear language' (Z= -11.47), 'Should give chance to ask questions' (Z= -9.17), 'Should provide summary and plan' (Z= -11.76), 'Should give detailed explanation' (Z= -10.16) and 'Should disclose outcome and prognosis' (Z= -11.68). The questions on 'Should provide warning' and 'Should be undisturbed atmosphere' actually was better in reality compared to patient desire as shown in Table 8 in further detail.

Table 8: Comparison of Patient preference and actual performance, SPHMMC, Addis Ababa, 2019

Question	Preference		Reality	Test statistics ^a		
	Patient satisfied (%)	('entirely satisfied')(%)		Z	Asymp. (2-tailed)	Sig.
Provide warning before	61.4		72.2	-2.711 ^b	.007	
Simple and clear language	61.9		21.4	-11.471 ^c	.000	
Give change to ask questions	59.4		26.2	-9.171 ^c	.000	
Provide summary and plan	52.8		10.1	-11.769 ^c	.000	
Ask if want to bring family or friends	47.8		55.8	-1.942 ^b	.052	
Give detailed explanation	47.5		13.6	-10.167 ^c	.000	
Disclose outcome and prognosis	53.5		11.4	-11.685 ^c	.000	
Should be undisturbed atmosphere	46.4		59.5	-3.144 ^b	.002	
Adequate time	47.8		18.7	-8.545 ^c	.000	
Should be empathetic	42.8		22.3	-5.980 ^c	.000	

^a Wilcoxon signed-rank test, ^b based on positive ranks, ^c based on negative ranks

Physician

One hundred and eleven physicians of all levels of training participated in the study. Majority were male (73%), the median age was 28 years and mean age 30.1 with age ranges from 22 to 55 years. Most of the participants were in the 26-30 years age group because the sample size mainly consisted of residents. As per the sample size 61 (55%) were internal medicine residents, followed by 22 (19.8%) seniors, 4 (3.6%) fellows and 8 general practitioners (7.2%) and 16 interns (14.4%) who are undergoing or have completed internal medicine rotation. In congruence to the common age group 95 (85.6%) have completed their undergraduate studies within the past 10 years. Other than internal medicine residents, general practitioners and interns, cardiology was the most

frequently participating specialty with 9 (8.1%) participation followed by internists 6 (5.4%). This will be illustrated in detail below in table 9 and figure 2.

Table 9: Sociodemographic characteristics of physicians, SPHMMC, Addis Ababa, 2019

Characteristics	Frequency	Percent
Gender		
Male	81	73.0
Female	30	27.0
Age		
20-25	20	18.5
26-30	56	51.9
31-35	15	13.9
36-40	7	6.5
41-45	5	4.6
> 46	5	4.6
Total	108	100.0
Marital status		
Married	40	36.0
Single	70	63.1
Widowed/other	1	.9
Job Title		
Intern	16	14.4
General practitioner	8	7.2
Fellow	4	3.6
Resident	61	55.0
Specialist	22	19.8
Time since graduating		
1 to 10 years	95	85.6
10 to 20 years	13	11.7
more than 20 years	3	2.7

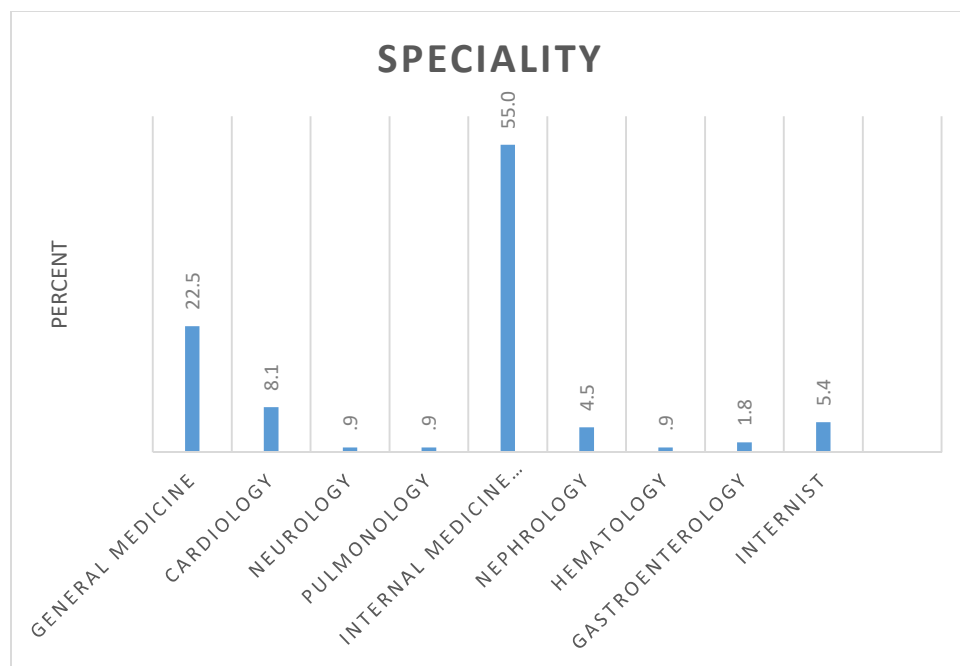


Figure 2: Specialty of physician participants, SPHMMC, Addis Ababa, 2019

Among the study participants 24 (21.6%) completed their undergraduate studies at SPHMMC. SPHMMC dominated because the majority of interns practicing currently are from the college. Following SPHMMC, other frequently stated medical schools were University of Gondar with 22 (19.8%), Jimma University 18(16.2%), Addis Ababa University 11 (9.9%), and Mekelle University 7 (8.3%). The rest is accounted for by 11 other medical schools including two participants who had their studies in Egypt and Sudan.

None of the above sociodemographic characteristics showed any statistically significant association with awareness of the protocol but specialty approached significance with P-value of 0.071.

Awareness and practice of SPIKES protocol

Among the participants of the study 87 (82.1%) were not aware of the SPIKES protocol and 93 (83.8%) haven't had any specific teaching or training on bad news delivery. Among the 17 participants who answered yes to have received a training, 11 (64.7%) had formal teaching, 5 (29.4%) sat and observed interviews and 1 person had both forms of training. After reading the definitions and components of the protocol 76 (71%) responded that they feel it is practical and

can be used in everyday practice. Thirty two (29.9%) of participants do not have any consistent approach to break bad news but the rest have either a consistent plan (22.4%) or employ different tactics (47.7%). Majority (80.9%) deliver bad news ten or less times per month.

Participants were asked to select the commonly used definition of bad news and 63.9% chose the correct definition but the rest 36.1% picked the definitions not used as standard.

Table 10: Questions on SPIKES protocol, SPHMMC, Addis Ababa, 2019

Question	Frequency	Percentage
Awareness of SPIKES		
Yes	19	17.9
No	87	82.1
Is it practical?		
Yes	76	71
No	31	29
Do you have plan/Strategy		
Have plan	24	22.4
Tactics but no plan	51	47.7
No	32	29.9
How often per month		
< 5 times	46	41.8
5-10 times	43	39.1
11-20 times	14	12.7
>20	7	6.4
Specific teaching?		
Yes	18	16.2
No	93	83.8
Where you deliver bad news/Ambulatory		
Private	88	79.3
Non- Private	23	20.7
Where you deliver bad news/Bedridden		
Sitting	47	42.3
Standing	64	57.7

Regarding place of communication, most (79.3%) said they would look for a private place for discussion if the patient is ambulatory but 57.7 % said they would deliver the news standing by the bed and not sitting if the patient was not ambulatory.

Participants were asked which part of the SPIKES they would find the easiest to accomplish and 25.6% said Knowledge part was the easiest followed by Perception (20.6%), Empathy (18.8%), Setting (16.9%), Invitation (9.4%) and last was Summary (8.8%). The opposite question asking about the most difficult part was also asked and Setting (28%) was the most difficult part followed by Perception (21.6%), Empathy (20.8%), Summary (10.4%) and 9.6% each responded for Invitation and knowledge.

Two further and deeper questions were included regarding the most difficult task and part. For the first question on most difficult task 36.2% responded that “talking about end of active treatment” was the most difficult task followed by “discussing end of life issues” (34.8%), “discussing diagnosis” (18.8%), “discussing recurrence” (5.8%) and least selected option was “involving family” (4.3%). The second question about difficult part identified “being honest without taking away hope” (39.8%) then “dealing with emotion” (32.8%), “spending right amount of time” (14.8%), “involving patient family in decision” (9.4%) and least selected option was “involving friends/family” (3.1%).

Attitude of physicians towards SPIKES protocol

Participants were asked to rate their own ability to break bad news and 56.8% said it was fair, 32.4% said it was very good or good and 10.8% replied poor. 54.1% rated their comfort with dealing with patient’s emotions as “not very comfortable” and 32.4% said they were uncomfortable.

Eighty-three percent think that patients should be told everything about their disease and among them 74.4% said they should be disclosed partially with each visit. 52.3 % believe that disclosing all information will take away patient’s hope and reduces their survival. The majority (95.5%) think that patients want to know about their diagnosis and prognosis and 85.6% feel like resuscitation should be discussed with patients. They responded that patients should be informed first in 34.5% of the cases, while 42.3% believe that family should know first while 22.5% believe that both family and patient should be disclosed first.

Participants were given a scenario where the relatives want to hide the bad news and asked what they would do. Some (39.1%) responded that they would tell the patient; 28.2% said they would tell the patient if asked; 21.8% chose to let the family take the patient to another physician who

would comply with their request. 7.3% would avoid the question while 3.6% would comply with the family and lie to the patient.

Awareness of the protocol did not show statistically significant correlation with having previous training but only 16 individuals had previous training.

Effect on physicians

Finally two multiple response questions were provided asking to select what emotions they have after they have broken bad news to patients. Half responded that they feel depressed and 25.8% said they actually feel relieved. Similarly they were asked what fears they had to give bad news and 46.5% responded by choosing fear of ending patient's hope and 31.6% feared patient's reaction. Fear of death was selected by 4.3% of participants.

Table 11: Questions on emotional response, SPHMMC, Addis Ababa, 2019

Question	Frequency	Percent
Emotions after breaking bad news		
Depressed	78	50.3%
Pity	19	12.3%
Relieved	40	25.8%
Unsafe	7	4.5%
Fearful	6	3.9%
Angry	5	3.2%
Fears in giving bad news		
Being blamed	17	9.1%
Ending hope	87	46.5%
Fear of death	8	4.3%
Fear of own reaction	16	8.6%
Fear of patient reaction	59	31.6%

5.2. Discussion

Specific components of the protocol were evaluated in different previous studies. Performance of Setting-part in this study was 74.5% similar to a recent Polish study published in 2018, which was 70.6%. Similarly, specific questions assessing Setting like separate room was 59.5% in this study

compared to 65.3%. Having separate room is essential to ensure patient privacy and comfort and more needs to be done to ensure it [3]. Different response was seen with regards to being asked to bring family with 55.8% in our study compared to only 31.7% in a 2015 Saudi Arabian study. This difference could be explained by the cultural and religious differences where family is more engaged in communication and patients may be more likely to call on family to facilitate communication process. Response to physician being seated was higher in our study compared to the earlier study, 88.6% and 73.3% respectively and eye contact was also higher 94.2% versus 75.7%. Sitting down gives assurance that the physician is willing to give adequate time and reassures patients [3, 21].

Performance of perception assessment was 51.1% compared to only 27.7% and Invitation was sought in 56.3% of the time compared to only 30.4%. These two components help physician recognize patient's view and current status and suggest how to approach the conversation [3].

The biggest difference between the studies was seen with Knowledge showing mean result of only 15.9% compared to 72.8% [3]. This difference can be explained by the fact that disclosure of prognosis was included in our study which is not part of the other study and had positive response of only 11.4%. Patients want their prognosis disclosed in 53.5% of the time but other studies show different numbers with more than 89% wanting to be informed [4, 6, 21]. The other knowledge question which asks about use of understandable language which was also low (21.4%) in this study could potentially have resulted from the different languages used by patient and physician [3, 31].

The Emotion part also varied significantly with 22.3% percent only giving entirely satisfied response in this study compared to 75.3. This is very concerning as studies have shown that lack of sympathy can lead to patient dissatisfaction. It is considered that communication skills can be trained and this might be attributed to lack of training or due to lack of proper setting including adequate time, space or language differences which make communication challenging [3].

The final component, Summary was accomplished in only 22.3% compared to 56.9% which could also potentially be explained by lack of proper setting similar to Emotion [3].

Patient desire for clear language use is slightly lower in our study compared to a 2014 study in Germany (61.9 Vs 94%), as it was for need for detailed explanation (47.5 Vs 93%), undisturbed

atmosphere (46.4 Vs 86%), adequate time (47.8 Vs 94%) and ability to ask questions (59 and 93%) [4].

Patient satisfaction is by far the most widely used, indirect measure for evaluating the effectiveness of physician-patient communication [25]. Patient satisfaction with how bad news was communicated was 30.6%, which is lower compared the German study that showed a satisfaction of 46.2% [4]. Previous studies have shown that satisfaction and patient-physician communication can be affected by communication skill, physician's fear of emotional response, physician avoidance and reluctance towards bad news and lack of training among others. This study however has shown that asking how much information patients like to be given affects their satisfaction. It can be said that this low level of satisfaction can be attributed to the significant discrepancy between patient desire and actual communication. Similar to this study, incongruence was seen in communicating with clear language, ability to ask questions, summarization, detailed explanation, disclosing prognosis and giving adequate time were also seen in the German study [4, 7]. Patients who were entirely satisfied with the knowledge they were able to attain was only 19.2% compared to 56.9%. This is in line with the significant mis-match for desire for knowledge in this study [3].

Among this study 82.1% of participating physicians are not aware of SPIKES protocol which was 60% in one study. However, another recent study published in 2017 where patients were asked if they knew any protocol and none were aware of any [15]. Only 63.9% picked the correct definition compared to 99.1% in another study. 83.8% did not have any prior training. This is higher than another studies where 51.2 % to 70.6% have prior training which was either medical school ethics study or by observing clinicians. This inadequacy of awareness is likely due to the lack of much needed training [7, 14, 15, 17].

Participants think that patients should be informed first in 34.5% of the time which is similar to a Saudi study of 31.2% and 11.7% in another. On the other hand a different study showed preferences of 86.3%. This may be influenced by the society's cultural practices where family deals with patient affairs instead of direct patient involvement. Strong family influence might make physicians adjust to family demands and make the social interaction easier at the cost of patient's right to confidentiality. This has significant legal implications in that unless patients give consent or are unable to comprehend the discussion, by law they should be the ones to receive the news even if the physician suspects it will have negative effect on them. Physicians could also be subject

to litigation. Cultural influences show variable attitudes in different countries like Saudi Arabia and Korea compared to United States and other areas [7, 13, 14, 17].

In both our study and in the ASCO study the most difficult task was considered to be talking about end of active treatment and the most difficult part was being honest and taking away patient's hopes. Specific questioning on the components of the protocol showed Knowledge and perception were the easiest parts in our study compared to setting and knowledge. On the contrary, setting was the most difficult as opposed to Empathy. As shown from both physician and patient perceptions setting is an important part of the protocol that needs further work and this shows that in addition to physician factors hospitals and administrators also need to engage in providing appropriate settings and consider it as important part of patient care. Around 80% in both studies judged their ability as good or fair. More participants (86.5%) were uncomfortable or not very comfortable compared to 67.3%. Only 71% of our participants think it is practical compared to 94.4%, which could be attributed to the lack of awareness. The above findings show that irrespective of the country and setting physicians tend to face similar challenges [7].

A 2017 study comparing the effects of a training workshop has shown that physicians think that patients should be given partial information at a time in 92.2% of the time which was 74.4% in our study. 52.3% of our participants believe that disclosure will take away patient's hopes but only half that (25.5%) in the comparison study [17]. Previous studies including a 2007 systematic review have shown that disclosure of diagnosis or prognosis does not usually increase patient anxiety and can have benefits including helping patients decide on their subsequent management and can actually increase their hope. On the contrary, withholding information from patients has shown to cause negative effects like increased stress on the family and physicians. [17, 30].

On the scenario given to patients assessing their judgment if asked by family to conceal information, in our study and the mentioned study respectively, response was 39.1% vs 29.4% on telling patient, 28.2% vs 60.8% if asked directly by patient and 21.8% vs 2% would let them go to another physician. 85.6% feel like resuscitation should be discussed with patients, an almost identical number to the study [17].

Half of the participants responded that they feel depressed after breaking bad news, 40.8% in another study and 31.6% feared patient's reaction compared to 58.6%, which show that our participants tend to experience more negative emotions like depression [15].

Numerous studies have shown that education and training on communication skills including on how to deliver bad news can improve physician confidence, skill, and decrease negative emotions associated with it. Many studies reveal that more than 80% of physicians feel that training should be part of the undergraduate or the residency program [7, 14, 15, 16].

Strengths

As to the authors knowledge there are no large scale studies done on the subject particularly in internal medicine. Large number of patients were included in the study and it was attempted to have comprehensive results that incorporates both patient and physician perspective. It serves as a very important starting point for other institutions and other departments to take initiatives on this important issue.

Limitations

Both patients and physicians assessed the level of performance of SPIKES themselves with subjective questionnaires and it may not show the magnitude of the real problem. Objective studies with video recording of interviews with structured and standardized evaluation tools would reveal results that are more accurate. Many patients started their treatments at other hospitals with different physicians and results cannot be generalized to SPHMMC. Wider studies at other hospitals should be done to properly know the magnitude of the problem. The protocol was developed in United States and is still mainly validated in developed countries. It should be validated in future studies taking into account the cultural and resource limitations available in this country.

Chapter VI: Conclusions and recommendations

Conclusions

Every physician at many times will be confronted with the task to deliver undesired news to patients. Many guides have been developed and SPIKES protocol seems to have gained more universal acceptance. Despite SPIKES being developed initially for oncology patients findings of patient satisfaction were similar for malignancies and non-oncologic medical disorders highlighting the importance of giving attention to the communication process particularly in delicate situations like disclosing bad news to patients. Our medical patients share similar challenges in dealing with incurable illnesses and grim prognosis and on top of this are not entirely satisfied with the communication with their physicians.

Poor performance with respect to the components of the protocol was seen. This includes activities such as asking what patients know, giving detailed information about the disease and even summarizing the discussion that do not demand much resources other than devotion, empathy and time of physicians.

Patient's desires on how to be told their news is very different from how it actually is done and patients are not satisfied with the communication process and with the knowledge they attain during bad news delivery. Physicians should be able to ask what patients want to know as it has effects on their satisfaction.

Most of the participating physicians were not aware of the protocol nor did they ever receive any training. Many were not comfortable dealing with patient emotions and do not rate their ability as good. Delivering bad news is a challenging act and can lead to feelings of depression, fears of ending patient's hopes and fear of patient's reaction.

Recommendations

A caring relationship should be established with the patients and families and their treating physicians should inform them of the benefits of disclosure to the patient. Physicians should be sitting, give clear and detailed explanation including prognosis, in a comfortable environment and end up by summarizing future plans of care without fearing patient's social and education background. They should prepare adequate time and comfortable place for discussion setting an opportunity to ask questions and have a sympathetic approach while doing so. They should have

a specific plan to address these issues and can benefit from using a protocol with practical steps. Physicians believe that patients should be informed with serial visits and should arrange for future discussions.

The belief that disclosure takes away hope is unfounded; it should be abolished and replaced with empathetic communication. Patients may desire their family to be present but confidentiality and privacy should be respected and family should be made aware only with patient's request.

But not all responsibility should be left to the physicians. Finding proper setting was identified as a major impediment and the entire health care system should be organized recognizing patients' needs for a conducive atmosphere for discussion. This should be the responsibility of healthcare institutions, hospital administrators, quality assurance offices, healthcare consultants and major regulators like Ministry of health. Undergraduate medical schools along with fellowship programs should be designed in a way to prepare their students starting early on what a proper way of communication is and incorporate SPIKES protocol in to their studies. Practical demonstrations and other skill building exercises should be part of routine teaching process with strict follow-up schemes and regular updates should be provided as needed. This should be applied by teachers, curriculum developers, accreditation bodies like Higher Education Relevance and Quality Agency, ministry of health and ministry of education.

Conflict of interest: none declared

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Annex

Appendix 1: *Physician questionnaire*

Title: Disclosing bad news to medical patients at St. Paul's Hospital Millennium Medical College, physicians' knowledge and practice of using SPIKES protocol and patient satisfaction: a descriptive cross-sectional study

Investigator: Henok Fisseha, M.D., internal medicine department, SPHMMC

Phone: 0913729110

Introduction and Purpose of the study: Greetings, you are being asked to participate in a study examining disclosure of bad news to medical patients at SPHMMC, use of SPIKES protocol and patient satisfaction. You were selected because you are a physician working in the department. Please read the form and feel free to ask any questions you may have to the investigator.

Procedure: If you agree to this study you will fill the questionnaire below which will take only few minutes.

Risks: I anticipate no risk to you

Benefits: Your participation will greatly enhance patient care and satisfaction and will assist in formulating medical school curriculums.

Confidentiality: The study will be anonymous, findings will be strictly confidential, and your identification will not be mentioned. All information will be kept in a password protected computer.

Payment: You will not receive any payment for your participation except gratitude.

Right to refuse or withdraw: You may refuse any time to participate in the study and can withdraw your consent for the data gathered to be used.

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

Subject's Name:

Subject's Signature: Date:

Investigators signature:

Section I: Socio-demographic characteristics

1. Age

2. Gender

Male ☐

Female ☐

3. Marital status

Married ☐ Divorced ☐

Single ☐ Other ☐

4. Job title

Intern ☐ Fellow ☐

General practitioner ☐ Specialist ☐

Resident ☐

5. Time since graduation (undergraduate study)

1 to 10 years ☐ More than 20 years ☐

10 to 20 years ☐

6. Specialty

General medicine ☐ Internal medicine resident ☐ Internist ☐

Cardiology ☐ Nephrology ☐

Neurology ☐ Hematology ☐

Pulmonology ☐ Gastroenterology ☐

7. Place of undergraduate training:_____.

Section II: Knowledge and practice

8. Which do you think is a commonly used definition of bad news delivered to patients?

All information that causes physical harm to the patient ☐

Information that gives news of death ☐

Any information transmitted that implies any negative change and could affect the individual's outlook on life or their perspectives on the future. ☐

9. Are you aware of SPIKES protocol of breaking bad news?

Yes ☐ No ☐

10. Which element of the below mentioned SPIKES protocol do you think you would find easiest? (**all questions below need to be filled irrespective of above answer**) (select one)

S-Setting up the interview (finding time, privacy, place, interpreter...) ☐

P-perception (assessing patient's perception, asking what they already know) ☐

I-Invitation (getting patient's invitation to share information) ☐

K-Knowledge (sharing knowledge and information) ☐

E-Emotion/Empathy (addressing patient's emotions with empathy) ☐

S-Strategy/Summary (discussing future plan, summarizing) ☐

11. Which element of the SPIKES protocol do you think you would find most difficult?

S-Setting ☐

P-Patient's perception ☐

I-Invitation ☐

K-Knowledge ☐

E-Exploring/Empathy ☐

S-Strategy/Summary ☐

12. Do you feel that the SPIKES protocol is practical and can be used in your clinical practice?

Yes ☐

No ☐

13. When you break bad news to patients, do you have a consistent plan or strategy in mind?

Have a consistent plan or strategy ☐

Several techniques/tactics but no overall plan ☐

No consistent approach to task ☐

Section III: Practice

14. In an average month, how often do you have to break bad news to a patient (e.g., diagnosis, recurrence, prognosis of disease)?

Less than 5 times ☐ 10 to 20 times ☐

5 to 10 times ☐ More than 20 ☐

15. Which do you find the most difficult task?

Discussing diagnosis ☐

Telling patient about recurrence of an illness ☐

Talking about end of active treatment and beginning palliative treatment ☐

Discussing end-of-life issues (e.g., do not resuscitate) ☐

Involving family/friends of patient ☐

16. What do you feel is the most difficult part of discussing bad news?

Being honest but not taking away hope ☐

Dealing with the patient's emotion (e.g., crying, anger) ☐

Spending the right amount of time ☐

Involving friends and family of the patient ☐

Involving patient or family in decision-making ☐

17. Have you had any specific teaching or training for breaking bad news?

Yes ☐ No ☐

18. If yes to the above question what was the training?

Formal teaching ☐

Sat in with clinicians in breaking bad news interviews ☐

Both ☐

19. Where do you give bad news if the patient is ambulatory?

Search for a private place ☐

Inform in a non-private ☐

20. If the patient is bedridden, where do you give bad news?

Inform sitting by the bed ☐

standing by the bed ☐

Section IV: Attitude

21. How do you feel about your own ability to break bad news?

Very good ☐

Good ☐

Fair ☐

Poor ☐

Very poor ☐

22. How would you rate your own comfort in dealing with patient's emotions (crying, anger, denial)?

Quite comfortable ☐

Not very comfortable ☐

Uncomfortable ☐

23. Do you feel comfortable in discussing with patient/relatives issues concerning diagnosis, prognosis, and life expectancy?

Quite comfortable ☐

Not very comfortable ☐

Uncomfortable ☐

24. Do you feel patient should be told everything about their disease?

Yes ☐ No ☐

25. If yes, how do you think patient should be told?

Everything in a single visit ☐

Partial information in each visit ☐

26. Do you feel telling all information to patients takes away their hope and their survival declines?

Yes ☐

No ☐

27. If the relatives want to hide the diagnosis/prognosis what would you do?

Agree with the relatives and lie to the patient ☐

Agree with relative and avoid difficult questions ☐

Tell them to take the patient to a doctor who agrees to whatever the relatives say ☐

Tell them that if the patient asks them they will tell the truth, but if the patient doesn't ask you won't tell ☐

Disagree with relatives and tell the diagnoses and prognosis to the patient ☐

28. Do you think patients want to know about their diagnosis and prognosis?

Yes ☐

No ☐

29. Do you feel issue of resuscitation should be discussed with the patient or relatives?

Yes ☐

No ☐

30. Who should receive the bad news first?

Patient ☐

Family ☐

Both ☐

Section V: Effect on physician

31. Which of the following describes your emotions after breaking bad news? (**can have multiple answers**)

Depressed or Sad ☐

Pity ☐

Feeling of fulfilled duty or Relieved ☐

Unsafe ☐

Fearful ☐

Angry ☐

32. What fears do you have in giving bad news? (**can have multiple answers**)

Fear of being blamed ☐

Fear of ending the patient's hope ☐

Fear of death and illness itself ☐

Fear of your own emotional reactions ☐

Fear of the patient's reactions ☐

Appendix 2: ***Patient questionnaire***

Title: Disclosing bad news to medical patients at St. Paul's Hospital Millennium Medical College, physicians' knowledge and practice of using SPIKES protocol and patient satisfaction: a descriptive cross-sectional study

Investigator: Henok Fisseha, M.D., internal medicine department, SPHMMC

Phone: 0913729110

Introduction:

Greetings, you are being asked to participate in a study examining disclosure of bad news to medical patients at SPHMMC, use of SPIKES protocol and patient satisfaction. You were selected because you are admitted in the time frame of the study and you have received a required diagnosis.

Please read the form and feel free to ask any questions you may have to the investigator.

Purpose of the study: is to know patient satisfaction when breaking bad news by physicians. It is aimed to improve physician skill and know patient desires. The research may be published in the future.

Procedure: If you agree to this study you will be asked questions including basic things about you and how the physician addressed you during the interview. It will take only few minutes.

Risks: there is no anticipated risk of participation and acceptance or refusal will not affect any further care.

Benefits: It will help improve communication skill of doctors, provide them with training, and help them be more empathetic to patients.

Confidentiality: The study will be anonymous, findings will be strictly confidential, and your identification will not be mentioned. All information will be kept in a password protected computer.

Payment: You will not receive any payment for your participation except gratitude.

Right to refuse or withdraw: You may refuse any time to participate in the study and can withdraw your consent for the data gathered to be used.

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

Subject's Name:

Subject's Signature: Date:

Investigators signature:

Section I: Sociodemographic characteristics

1. Age_____.

2. Gender

Male ☐ Female ☐

3. Current marital status : Married ☐ Widowed ☐ Divorced ☐ Single ☐

4. Education level attained

Illiterate ☐ Secondary school education ☐

Primary school education ☐ Certificate, diploma, degree or higher ☐

5. Occupation

Government employee ☐ Student ☐

Farmer ☐ Unemployed ☐

Works in private employment ☐ Other ☐

6. Residence Urban ☐ Rural ☐

7. What is the bad news that you received? (specify also if it was diagnosis and/or prognosis)

8. Where were you informed of the news in the above question and please mention if other

This hospital ☐ Health center ☐ Another hospital ☐ private clinic ☐

9. For how long have you known about your disease?

0 to 3 months ☐ 6 to 12 months ☐

3 to 6 months ☐

Section II: Perception of patients and the procedure of breaking bad news (unless specified answered according to: Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐)

10. The doctor held the conversation:

In a doctor's office or clinic ☐ On the phone ☐

In a patient's room ☐ Other location, specify if so ☐

11. Did the doctor invite you to a separate room or place for the interview? Yes ☐ No ☐

12. Did the doctor ask, if you would like someone from your family with you? Yes ☐ No ☐

13. Did the doctor sit down with you during the interview? Yes ☐ No ☐

14. Did the doctor maintain eye contact sufficiently? Yes ☐ No ☐

15. How did you find the intimacy (ቅርብ) of the interview? Entirely ☐ Very much ☐
Somewhat ☐ Not at all ☐

16. Did the doctor ask, if you were ready for this talk? Yes ☐ No ☐
17. Did the doctor ask, at the beginning of the conversation, how much you had actually known about your disease? Yes ☐ No ☐
18. Did the doctor ask how much information you would like to be given? Yes ☐ No ☐
19. Did the doctor inform you that he has to deliver bad news? Yes ☐ No ☐
20. Did the doctor try to prepare you mentally for bad news?
Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐
21. Did the doctor use understandable language?
Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐
22. Were you given adequate time for discussion?
Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐
23. Were you emotionally supported (compassion (ርህራሄ), understanding) by the doctor?
Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐
24. Did the doctor allow you adequate opportunity to ask the questions you considered important? Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐
25. Did the doctor clearly explain any information given so that you understood?
Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐
26. Did the doctor make a concrete statement regarding your life expectancy?
Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐
27. Did the doctor make a plan for the future and summarize the discussion?
Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐
28. During the conversation with your doctor did you became sad?
Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐
29. During the conversation with your doctor did you became angry?
Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐
30. During the conversation with your doctor did you became desperate (ተስፋ ማጣት)? Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐

31. Were you offered another conversation? ☐ Yes ☐ No

If yes, with a: ☐ Priest or other religious leader ☐ Psychologist ☐ Someone else

32. After the conversation did you trust your doctor's advice?

Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐

33. After the conversation did you feel less anxious and worried?

Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐

Section III: Suggestions on how doctors can improve breaking bad news: Patients desire grading (Entirely/strongly agree = 4, Very much/agree = 3, Somewhat/disagree = 1, and Not at all/strongly disagree = 0)

Should warn me earlier that I have some serious news _____.

Should be simple and clear in delivering the news _____.

Should check if the message has been understood _____.

Should be given possibility to ask questions _____.

Summarize and establish a plan for how to move on _____.

Should ask me to bring a family member or other important person with me _____.

Should give detailed explanation of disease _____.

Would you like to be told about outcome and prognosis _____.

The conversation should be held by a doctor of the same sex as the patient _____.

The conversation should be held in an undisturbed atmosphere_____.

The doctor should take enough time _____.

The doctor should try to be empathic _____.

Section IV: Satisfaction

When the visit was completed, were you satisfied with your knowledge about the disease and its further management? Entirely ☐ Very much ☐ Somewhat ☐ Not at all ☐

How do you rate your satisfaction with the overall interaction with the physician while he broke the bad news? Entirely/strongly ☐ Very much/satisfied ☐ Somewhat/ dissatisfied ☐ Not at all/ strongly dissatisfied ☐

የታካሚ መጠየቅ

ርዕስ: - በቅዱስ ጳውሎስ ሆስፒታል ሚሊኒየም ሜዲካል ኮሌጅ ለሚገኙ የህመማን መጥፎ ዜናዎች መግለፅ ፣ የሐኪሞች የ SPIKES ፕሮቶኮልን የመጠቀም እና የታካሚ እርካታ ጥናት

መርማሪ: ሄኖክ ፍስሀ ፣ ኤም.ዲ. ፣ የውስጥ ደዊ ክፍል ፣ ቅ/ጳ/ሆ/ሚ/ሜ/ኮ

ስልክ: 0913729110

መግቢያ

ሰላም ፣ በ ቅ/ጳ/ሆ/ሚ/ሜ/ኮ ላሉት ህመምተኞች ፣ የ SPIKES ፕሮቶኮልን እና መጥፎ ዜናን ማጋራት የታካሚ እርካታን በተመለከተ በሚመረምር ጥናት ላይ እንዲሳተፉ ይጠየቃሉ ። እርስዎ የተመረጡት ምክንያት በጥናቱ የጊዜ ሰንጠረዥ ውስጥ ስለገቡ እና የተመረጡ በስታ ስላሉት ነው።

እባክዎን ቅጹን ያንብቡ እና ለመርማሪው ሊኖርዎት የሚችለውን ማንኛውንም ጥያቄ ለመጠየቅ ነፃነት ይሰማዎ ።

የጥናቱ ዓላማ-በሐኪሞች መጥፎ ዜና ሲነገር የሕመምተኛ እርካታን ማወቅ ነው ። ዓላማው የሐኪም ችሎታ ለማሻሻል እና የታካሚዎችን ፍላጎት ለማወቅ ነው። ጥናቱ ለወደፊቱ ሊታተም ይችላል ።

ሥነ-ሥርዓት- በዚህ ጥናት ከተስማሙ ስለእርስዎ መሰረታዊ ነገሮችን እና በቃለ-መጠይቁ ወቅት ሐኪሙ እንዴት እንዳነጋገረዎት ይጠየቃሉ ። የሚወስደው ጥቂት ደቂቃዎችን ብቻ ነው።

ስጋት- የመሳተፍ ወይም የለመሳተፍ ምንም ዓይነት ተጨማሪ የጤና ሁኔታና ህክምና ላይ ተጽዕኖ የለውም ።

ጥቅሞች : - የይክተሮች የግንኙነት ችሎታ ለማሻሻል ፣ ስልጠና እንዲያገኙ እና ለበሽተኞች የበለጠ ርህራሄ እንዲኖራቸው ይረዳል ።

ምስጢራዊነት - ጥናቱ ስም-አልባ ይሆናል ፣ ግኝቶች በጥብቅ ምስጢራዊ ይሆናሉ ፣ እና መታወቂያዎ አይጠቀስም ። ሁሉም መረጃዎች በይዘቱ ቃል የተጠበቀ ከምፒተር ውስጥ ይቀመጣሉ ።

ክፍያ : - ከምስጋና ውጭ ካልሆነ በስተቀር ለተሳትፎዎ ምንም ክፍያ አያገኙም።

የመቃወም ወይም የመልቀቅ መብት-በጥናቱ ለመሳተፍ በማንኛውም ጊዜ እምቢ ማለት ይችላሉ እና ጥቅም ላይ የዋለው መረጃ ጥቅም ላይ ለመዋል ፈቃድዎን ማንሳት ይችላሉ ።

ከዚህ በታች ያለው ፊርማዎ ለዚህ ጥናት እንደ ተሳታፊ ሆነው ለመሳተፍ መወሰኖን እና ከዚህ በላይ የቀረበውን መረጃ እንዳይነበቡ እና እንደተረዱ ያሳያል ።

የታካሚ ስም

የታካሚ ፊርማ-

ቀን

ክፍል 1-የስነ-ልቦና ባህሪዎች።

1. ዕድሜ.

ፆታ

ወንድ ☐ ሴት ☐ ::

3. የወቅቱ የጋብቻ ሁኔታ-ያገባ ☐ የትዳር ጓደኛ በሞትየተለየ ☐ የፈታ ☐ ያላገባ ☐ ::

4. የትምህርት ደረጃ ላይ ደርሷል ::

ማንበብና መጻፍ ☐ የሁለተኛ ደረጃ ትምህርት ☐

የመጀመሪያ ደረጃ ትምህርት ☐ የምስክር ወረቀት ፣ ዲፕሎማ ፣ ድግሪ ወይም ከዚያ በላይ ☐ ::

5. ሥራ

የመንግሥት ሠራተኛ ☐ ተማሪ ☐ ::

ገበሬ ☐ ሥራ አጥ ☐ ::

በግል ሥራ ውስጥ ☐ ሌላ ☐ ::

6. የመኖሪያ ከተማ ural ገጠር ☐ ::

7. የተቀበልኩት መጥፎ ዜና ምንድነው?

8. ከላይ በተጠቀሰው ጥያቄ ውስጥ ወሬ የት ተነገሮ?

ይህ ሆስፒታል ☐ የጤና ጣቢያ ☐ ሌላ ሆስፒታል ☐ የግል ክሊኒክ ☐ ::

9. ስለ በሽታዎ ለምን ያህል ጊዜ ያውቃሉ?

ከ 0 እስከ 3 ወር ☐ ከ 6 እስከ 12 ወር ☐ ::

ከ 3 እስከ 6 ወር ☐

ክፍል II የሕመምተኞች ዕይታ እና መጥፎ ዜና የመስበር ሂደት (በዚህ መሠረት ካልተገለጸ በስተቀር ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን ☐ በጭራሽ ☐)

10. ሐኪሙ ውይይቱን ያረገው፡ -

በሐኪም ቤት ወይም ክሊኒክ ውስጥ ☐ በስልክ ☐ ::

በታካሚዎች ክፍል ውስጥ ☐ ሌላ ሥፍራ ፣ ካለ እንደዚህ ይግለጹ ☐

11. ለቃለ-መጠይቁ (ዶክተሩ) ለቃለ መጠይቁ ወደ ተለየ ክፍል ወይም ቦታ ጋበዘዎት? አዎ ☐ አይ ☐ ::

12. ከቤተሰብዎ ውስጥ የሆነ ሰው ከእርስዎ ጋር እንዲኖር ከፈለጉ ሐኪሙ ጠየቀ? አዎ ☐ አይ ☐ ::

13. በቃለ-መጠይቁ ወቅት ሐኪሙ ከእርስዎ ጋር ተቀመጠ? አዎ ☐ አይ ☐::
14. ሐኪሙ የዓይን መገናኘትን በበቂ ሁኔታ ይከታተል ነበር? አዎ ☐ አይ ☐::
15. የቃለ መጠይቁን) ቅርበን እንዴት አገኙት? ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::
16. ለዚህ ንግግር ዝግጁ መሆኖን ሐኪሙ ጠየቀ? አዎ ☐ አይ ☐::
17. ሐኪሙ በውይይቱ መጀመሪያ ላይ ስለ በሽታዎ ምን ያህል ያውቁ እንደነበር ጠየቀ? አዎ ☐ አይ ☐::
18. ዶክተሩ ምን ያህል መረጃ ሊሰጥዎት እንደሚፈልጉ ጠየቀ? አዎ ☐ አይ ☐::
19. ሐኪሙ መጥፎ ዜና መንገር እንዳለበት ነገረዎት? አዎ ☐ አይ ☐::
20. ሐኪሙ እርስዎ ለመጥፎ ዜና በአእምሮዎ ሊያዘጋጁት ሞክረዋል?
ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::
21. ሐኪሙ ለመረዳት የሚያስችግር ቋንቋ ተጠቀመ?
ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::
22. ለውይይት በቂ ጊዜ ተሰጠዎት?
ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::
23. በዶክተሩ በስሜታዊ ድጋፍ ተደረገ (ርህራሄ (ስሜትን / መረዳትን) ተደርጎሎታል
ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::
24. አስፈላጊ እንደሆኑ ያዩዋቸውን ጥያቄዎች ለመጠየቅ ሀኪሙ በቂ እድል ፈጥሮልዎታል? ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::
25. ሐኪሙ የተረዱት ማንኛውንም መረጃ በግልፅ አብራራ
ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::
26. የህይወት ተስፋዎን በተመለከተ ሀኪሙ ተጨባጭ መግለጫ ሰጥቷል?
ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::
27. ሐኪሙ ለወደፊቱ እቅድ አውጥቶ ውይይቱን መጠቃለል ቻለ?
ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::
28. ከሐኪምዎ ጋር በተነጋገሩበት ወቅት ማዘን ተሰማዎት?
ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::
29. ከሐኪምዎ ጋር በተነጋገሩበት ወቅት ተናደዱ?
ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::

30. ከሐኪምዎ ጋር በተነጋገሩበት ወቅት ተስፋ ቆረጡ? ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::

31. ሌላ ውይይት ቀርቦልዎታል? አዎ ☐የለም☐::

አዎ ከሆነ ፣ ከሚከተለው ጋር፡ -

ካህን ወይም ከሌላ የሃይማኖት መሪ ☐የሥነ-ልቦና ባለሙያ ☐ከሌላ ሰው ☐::

32. ከውይይቱ በኋላ የይክተርዎን ምክር አመኑት

ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::

33. ከውይይቱ በኋላ የመረጠሽ ስሜት ቀነሰሎት?

ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን at በጭራሽ ☐::

ክፍል III-ይክተሮች መጥፎ ዜና መንገር እንዴት ማሻሻል እንደሚችሉ ላይ የቀረቡ ሀሳቦች- የእርሶ የታካሚ ፍላጎት(ሙሉ በሙሉ / በጥብቅ መስማማት = 4 ፣ በጣም / እስማማለሁ 3 ፣ ጥቂት / አልስማም = 1 ፣ እና በጭራሽ / ሙሉ በሙሉ አልስማም = 0)

አንድ አሳሳቢ ዜና እንዳለኝ ቀደም ብሎ ቢያስጠነቅቀኝ ።

ዜና በማሰራጨት ረገድ ቀላል እና ግልፅ መሆን አለበት ።

መልዕክቱ የተረዳ መሆኑን ማረጋገጥ አለበት።

ጥያቄዎችን የመጠየቅ እድል ሊሰጠኝ ይገባል ።

ለመቀጠል የሚያስችል ዕቅድ ማጠቃለል እና ማዘጋጀት ።

አንድ የቤተሰብ አባል ወይም ሌላ አስፈላጊ ሰው ከእኔ ጋር እንድመጣ መጠየቅ ።

ስለ በሽታ ዝርዝር ማብራሪያ መስጠት አለበት ።

ስለ ውጤትና ስለ መጨው ጊዜ እንዲነገረዎት ይፈልጋሉ?

ውይይቱ እንደ በሽተኛው ተመሳሳይ ፆታ ካለው ሐኪም ጋር መደረግ አለበት ።

ውይይቱ በተረጋጋ አካባቢ ውስጥ መሆን አለበት ።

ሐኪሙ በቂ ጊዜ መውሰድ አለበት ።

ሐኪሙ ሩህሩህ ለመሆን መሞከር አለበት።

ክፍል 4-እርካታ ።

ጉብኝቱ ሲጠናቀቅ ስለበሽታው እና ስለ ቀጣይ ህክምና ባሉት እውቀት ረክተዋል? ሙሉ በሙሉ ☐ በጣም ☐ በተወሰነ መጠን ☐ በጭራሽ ☐::

መጥፎ ዜናውን ሲነገሮት እያለ ከሐኪሙ ጋር ስላለው አጠቃላይ ግንኙነት እርካታዎ ምን ያህል ነበረ? ሙሉ በሙሉ / በጥብቅ ☐ በጣም / እርካታ ☐ በተወሰነ ደረጃ ☐ በጭራሽ / በከፍተኛ ሁኔታ አልረካሁም ☐