



DOI: 10.19187/abc.201963124-130

Breast Cancer Patients' Preferences When Receiving Bad News: A Qualitative Study From a Middle Eastern Country

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ARTICLE INFO

Received:
30 July 2019
Revised:
14 August 2018
Accepted:
20 August 2019

Key words:
Bad News,
patients' preferences,
breast cancer

ABSTRACT

Background: Telling bad news to the patients after a diagnosis of breast cancer is one of the most important duties of a physician. The aim of this study was to explore breast cancer patient's preferences regarding how to receive bad news.

Methods: A group of 15 women with breast cancer were purposively recruited to this qualitative study. Semi-structured in-depth interviews were conducted to identify the patients' preferences through content analysis.

Results: The age of participants ranged between 28 and 58 years. Nine patients had undergone mastectomy and the remaining 6 had received conservative surgery. The minimum time between the diagnosis and receiving the news of cancer was 1 month, the maximum 15. Altogether, 250 codes were extracted after content analysis and categorized into 7 categories and 43 subcategories. The main categories were the method of disclosure of bad news, medical information, communication skills, emotional support, family involvement, the setting, psycho-spiritual care, and the word "cancer."

Conclusion: Knowing about patients' preferences regarding the methods of breast cancer diagnosis disclosure can help physicians to effectively deliver bad news. Therefore, it is necessary that the clinicians be informed about the themes that the patients consider important while delivering bad news to patients.

Introduction

Cancer, as a life-threatening disease, jeopardizes the patient's life.¹ In fact, receiving a diagnosis as serious and potentially fatal as cancer directly affects different aspects of a patient's life.² Thus, breaking the bad news of cancer diagnosis to patients is a challenging task because it impacts on the bio-psycho-social-spiritual health of the patient.³ Nevertheless, in accordance with patient rights and medical ethics, patients are entitled to receive

information about their disease and health condition.⁴

Bad news can cause strong emotional reactions in the receiver and, as a result, may exacerbate the prognosis of the patient.⁵ In the clinical setting, the news of cancer diagnosis, recurrence, or treatment failure is an example of bad news.⁶ The approach of physicians to breaking bad news to patients varies in different countries. In Western countries, it is quite normal to directly tell the patients of their status.⁷ In fact, according to professional medical ethics, disclosure is viewed as respecting the patient's autonomy.⁸ On the contrary, the straight forward approach for informing patients of their condition is not common in Eastern nations.⁹ Some physicians take a considerate approach when they want to deliver bad news to patients, trying to be honest about patient's health condition in a way that does

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not create further stress in the patient.¹⁰ They maintain this approach while communicating with the patient's close relatives, showing proper reaction to the patient's emotions¹¹ while discussing life expectancy and adverse outcomes.¹²

Despite the challenges and difficulties involved in effective disclosure of bad news, it can undoubtedly increase cancer adjustment in patients.¹³ Although there are a variety of protocols for breaking bad news, physicians always need to know how to inform the patients and what kind of information they are supposed to disclose.

The first step to do this would be to ask patients what they need to know.¹⁴ Studies have shown that the majority of patients are willing to know if they have cancer and whether their disease could be cured.¹⁵ About 91% of cancer patients in a study in China believed that patients should become aware of the truth about the nature of their disease.¹⁶ Patients require information about their clinical diagnosis because they believe the truth can help them plan for the rest of their lives and recover from the disease.²³ Butoco et al found that patients tended to be alone with their physician at the time of receiving the bad news and get the doctor's expert opinion about their life expectancy,¹⁷ while Marwit *et al.* observed that patients would prefer to receive such information in the presence of their close family through honest and transparent conversation.¹⁸

Fujimori *et al.* recognized that patients' preferences in receiving the bad news consist of four components: setting, manner of communicating, what and how much information to disclose, and emotional support. Patients expect the clinician to spend enough time communicating with them about the diagnosis, treatment, and its effects on their daily function.¹⁹ The patients prefer that the doctors refrain from using scientific jargon while giving bad news and provide clear explanations easily understandable by the patient and her family.²⁰

Another factor found to be important to patients is emotional support, which includes making an empathic statement after delivering bad news.²¹ They expect the physicians to understand their emotions and those of their family when the news is being given and talk to them with an appropriate and kind tone.²¹ In fact, providing emotional support, spending an appropriate amount of time to fully answer their questions, and providing useful information for understanding cancer are all considered crucial by patients.^{22,23}

Given the psychosocial differences between genders, it seems reasonable that men and women have different preferences and expectations in terms of receiving bad news. For instance, women tend to be more sensitive in receiving bad news and prefer to get it from their physicians.²⁴

Breast cancer is the most common cancer among women in the world. It is also one of the main causes

of cancer-related death among women.²⁵ Hence, consideration of the way the bad news is communicated to the patients is of utmost importance. The purpose of this study was to explore breast cancer patients' preferences for receiving bad news.

Methods

A qualitative method was used to identify the preferences of female patients in how to receive the news of their breast cancer. Application of the qualitative method here has been principally due to grave significance of the disclosure event from the standpoint of women with cancer.²⁶ Consequently, the content analysis method was deemed appropriate to analyze the data gathered.

The target population for this study was women with breast cancer in Tehran. Fifteen women were purposively selected from among the women admitted to one of the referral hospitals affiliated with Tehran University of Medical Sciences (2016 to 2017). Subjects were recruited from different age groups and various educational backgrounds to increase validity of the data. Written informed consent was obtained from each participant.

The ethics committee of Tehran University of Medical Sciences approved this study. For all the eligible participants, semi-structured in-depth interviews were performed and recorded in a proper setting. The interviews started with a short introduction to the subject and main purpose of the research, followed by general questions regarding the patients' experiences of receiving bad news from their physicians. Afterwards, more specific questions were asked including "Could you give me an example?" or "Could you explain it?" We also asked the following questions: How did you become aware of your disease? How would you have preferred to receive this news? In your opinion, which factors must be taken into account in giving the diagnosis news by the treatment team? The interviews were continued until the saturation point was reached, with each taking 110 to 120 minutes on average.

The Graneheim and Lundman method was applied to qualitatively analyze the data.²⁷ At first, the audio files were transcribed and then the transcripts were reviewed several times till a general understanding of them was obtained. Afterwards, the materials were transformed into condensed meaning units (sentences and paragraphs extracted from the participants' remarks). These units were then abstracted as codes. The primary coding was performed after multiple thorough reviews were done, and the meaningful units were explained and named. These units included words, phrases, or larger chunks from the transcripts. The researchers revised the data line by line to finally code each sentence. As such, maximum possible codes were specified so that it was ensured that all the information had completely been extracted.²⁸ Then, the coded data were compared and categorized. At

**Table 1.** Categories and subcategories of breast cancer patients' preferences regarding receiving bad news

Row	Category	Subcategory	Examples of Participants' Remarks
1	The method of disclosing bad news	<ul style="list-style-type: none"> •Telling the truth step by step •Making the proper introduction for telling the diagnosis •Preparing the patient •Telling bad news indirectly •Informing the patient about the diagnosis and treatment process •Giving a chance to choose between mastectomy and breast-conserving surgery after news disclosure •Answering the patient's questions 	<ul style="list-style-type: none"> •They should prepare the patient little by little so that they do not panic (a 45-year-old patient receiving mastectomy). •They should make an introduction and prepare the patient; it is much better than just directly telling them, especially for those with malignant tumors (a 31-year-old patient receiving mastectomy). •My doctors just told me they had to remove my breast in the first visit and gave me no chance to decide (a 31-year-old case receiving mastectomy).
2	Medical information	<ul style="list-style-type: none"> •Telling about breast cancer •Telling about treatment options and their side effects •Informing about disease control •Explain the recommended diet •Telling about the fertility implications of the disease •Discussing statistics of breast cancer patients and the chance of cure •Telling about hair loss and change of appearance in chemotherapy •Informing about recurrence and prognosis 	<ul style="list-style-type: none"> •I think anyone who has cancer should first know what it is and how it can be cured and if there is any treatment for it (a 35-year-old patient receiving mastectomy). •I preferred that my doctor tell me about the treatment options and their effects on me and my fertility. I would like to know about the proper diet during the treatment period, about the side effects of chemotherapy and changes in my appearance (a 31-year-old patient receiving breast-conserving surgery).
3	Communication skills	<ul style="list-style-type: none"> •Talking kindly and gently •Using understandable words •Showing respectful manners •Communicating to build trust •Providing relief and peace •Making the treatment seem natural •Giving realistic reassurance to patients •Understanding patients and their family •Showing empathy •Interacting in a way to give hope 	<ul style="list-style-type: none"> •When they told me the news, I panicked; but the doctor's words and tone relieved me and encouraged me to go on (a 37-year-old patient receiving mastectomy). •I really felt awful but my doctor inspired me and told me he would do everything he could, and this raised my hopes (a 40-year-old patient receiving breast-conserving surgery). •I cried a lot when they told me I had to be operated on and might undergo chemotherapy. But the doctor calmed me down and said he understood me and would stay by my side and everything was going to be all right (a 47-year-old patient receiving mastectomy).
4	Family involvement and support	<ul style="list-style-type: none"> •Presence of family and relatives during disclosure of bad news •Talking with the patient's family first •Using the family support to decrease the negative feelings induced by the bad news 	<ul style="list-style-type: none"> •If they first tell a relative, it will be better. It is no good just saying "your test results are bad, and you have to start [the treatment] right away" (a 45-year-old patient receiving mastectomy). •If they hadn't just told me and first had talked to my husband to tell me later or if they had told one of my relatives first, it would have been better for my mood. The way they talked to me gave me a huge shock and I was crying for two or three days (a 31-year-old patient receiving mastectomy).
5	Setting	<ul style="list-style-type: none"> •The doctors' availability •Respecting patients' privacy by asking the residents and other members of the treatment team to leave the room when disclosing the diagnosis •Devoting enough time for the patient •Providing a comfortable and peaceful environment •Telling the truth in a private, quiet setting 	<ul style="list-style-type: none"> •One feels better with their doctor, but when there are residents and other patients in the room, it gets really difficult, particularly when everybody is looking at you in a weird way, like you have cancer; when you are alone with your doctor and the setting is peaceful, there will be a positive feeling (a 33-year-old patient receiving mastectomy). •If they had told me the news in the doctor's office, I would have been feeling better; better than in the hospital. There were 3 or 4 residents standing by that could not fully explain matters. But in the office, it is much better, I mean, in a quiet place to talk to us for half an hour (a 45-year-old case receiving breast-conserving surgery).
6	Psycho-spiritual care	<ul style="list-style-type: none"> •Using psychotherapy service after disclosing bad news •Physicians' concern about patients' mental state •Providing palliative care •Invoking God at the time of breaking the news •Reminding patients that death is always decided by God •Being considerate of religious beliefs of patients 	<ul style="list-style-type: none"> •There was no psychologist or anyone to relieve me there. But women prefer to talk. They like to tell their problems to someone, someone who could understand them (a 33-year-old patient receiving mastectomy). •I suppose doctors must somehow know psychology and have some knowledge of it; they should be able to figure out the patient's capacity for the bad news at first sight. They should know how to speak; I mean they should be aware of how to handle each case (a 47-year-old case receiving mastectomy) •They told me life is in the hands of God and only in God we have to trust. Saying this relieved me (a 35-year-old patient receiving breast-conserving surgery)
7	The term "cancer"	<ul style="list-style-type: none"> •A frightening and stressful term •Its association with death •An incurable disease 	<ul style="list-style-type: none"> •Just mentioning "cancer" is terrible by itself; you know, it is huge! It scares people. (A 54-year-old patient receiving breast-conserving surgery). •They tell us we have cancer, and we think we are going to die because we believe we die when we get cancer (a 45-year-old patient receiving mastectomy).



this stage, related categories were identified and reclassified into new categories.

Following the initial coding, and to ensure the credibility of the data, they were given back to the participants for member checking and confirmation. To ensure the correctness of the codes, such measures as the external check (by specialists in breast cancer and medical ethics), immersion, and prolonged engagement were taken.

Results

In the present study, 15 women (age: 28-58) with breast cancer were interviewed. Nine of the participants had undergone mastectomy, 6 breast-conserving surgery. The time between diagnosis and receiving the bad news ranged from 1 to 15 months. Regarding educational status, 8 women had a high school certificate or a lower degree, and 7 were university graduates. Overall, 250 codes were extracted through content analysis and categorized into 7 categories and 43 subcategories (Table 1).

The Method of Disclosing Bad News

This category was one of the main concerns of patients and included 7 subcategories. In our setting, patients preferred that the news be given step by step, and the physician prepare them for receiving the news. To be indirectly informed of the details of their diagnosis was one of these preferences. In fact, it was very important to them that the doctor talk about diagnosis, management, prognosis, concerns, and questions and that they give them enough time to make a decision about the method of surgery (mastectomy or conservative surgery).

Medical Information

The other preference for the patients was receiving relevant medical information when the bad news is being broken to them. The patients would prefer to receive information on the following topics: the nature of breast cancer, treatment methods and their side effects, their diet during the treatment, effects of chemotherapy on their hair and appearance, and disease progression and recurrence.

Communication Skills

According to patient interviews, the physicians are expected to demonstrate good communication skills while delivering the bad news of cancer diagnosis. As shown in Table 1, there are 10 subcategories in this category. Patients prefer physicians to adopt a gentle approach and use an easy-to-understand language. Attention to the individual preferences of patients is required in order to create effective communication. Showing care and respect for the patient while opening a conversation about the fatal nature of cancer was very crucial, according to patients. Moreover, they expected to be understood as well as being heartened

while the news is being given to them. Undoubtedly, showing empathy toward patients would encourage them to comply with the treatment after they are informed of their disease.

Family Involvement and Support

This category encompassed 3 subcategories (Table 1). Participants preferred that their close family be present while they are receiving the news. Owing to the potentially supportive role of close relatives, the patients believed that involving them could reduce the negative effects of the bad news.

Setting

Paying appropriate attention to the setting (time and place) was among the patients' preferences in receiving the bad news. Five subcategories were identified for this category. Such factors as availability of the doctor, asking the residents and other members of the treatment team to leave the room, allowing the patient to ask questions and taking sufficient time to answer those questions, and arranging a private and quiet place without interruptions were the major topics here.

Psycho-spiritual Care

Another major concern of the patients was psycho-spiritual care, which consisted of 6 subcategories. Presence of a psychologist or a psychiatrist along with the physicians to provide psychological support and spiritual care during the disclosure of bad news was an expectation and preference of participants in this study.

The term "cancer"

Being careful with the use of the word "cancer" was another main preference of our participants, with 3 subcategories. Iranian patients consider this word to be frightening and very stressful as they associate this term with imminent death.

Discussion

The aim of this study was to explore breast cancer patients' preferences in receiving bad news. The most important preferences of the patients were the method of truth-telling, medical information, communicative skills, emotional support, family involvement, setting, psycho-spiritual care, and the word "cancer." These results are in line with those of Fujimori et al, who found that providing emotional support, giving medical information, and preparing a proper setting were important preferences of cancer patients regarding the disclosure of bad news.^{19,29}

The method of telling the truth was among the most important concerns to our participants. Indirect disclosure and preparing patients before giving the bad news, providing complete and transparent explanations about breast cancer, answering the questions of the patients and their relatives, and



giving patients the chance to select from among different treatment modalities were the most common participant preferences. According to the SPIKES protocol, one major aspect of the disclosure process is providing information which would be understandable for the patient and then checking whether the patient understood it, and, finally, avoiding the use of medical jargon.^{20, 22} Therefore, following the strategy for breaking bad news and providing support to the patient could substantially reduce stress and uncertainty in women with breast cancer.

Another preference mentioned by the patients was receiving relevant medical information about their disease, treatment modalities, side effects, the chance of being cured, recurrence rate, and how breast cancer would influence their daily lives. Buckman believes that physicians should ask patients if they want to know the details of the medical condition and/or treatment and then provide medical information according to the educational level and socio-cultural background of patients, in small chunks using clear and simple language.³⁰ Fujimori *et al.* found that young patients, women, and those with higher educational status are willing to receive more specialized information as to their disease and are more prepared to know the truth than other patients.³¹ Heydari *et al.* found that cancer patients need to get information on their disease and daily life. Therefore, the provision of realistic information by physicians within the disclosure process could decrease ambiguity in the treatment process.³²

Effective doctor-patient communication was another major concern to women with breast cancer in this study. Gebhardt *et al.* demonstrated that patient-centered communication skills could remarkably reduce patients' stress³³ and promote psychological adjustment in newly diagnosed breast cancer patients.³⁴ Cao *et al.* discussed patient-centered communication strategies for giving bad news, saying that patients expected emotional support from doctors and that personalized disclosure would lead to higher levels of hope and trust in them.³⁵ Previous studies have also emphasized emotional support and the establishment of a compassionate rapport as the main preferences of cancer patients during bad news disclosure.^{22,23}

Family involvement in the process of telling the truth was another preference of breast cancer patients in this study. Patients believe that the presence of their families at the time of receiving news about cancer diagnosis could reduce the negative impacts of the news. Studies have shown that family is the most important support system for cancer patients in Asia and Eastern Europe.³⁶ Patients favor the involvement of their close relatives in the disclosure process as they can get help from them for decision making.³⁷ Therefore, active involvement of families in the treatment process in a family-centered culture

like Iran can considerably help cancer patients in the time of disclosure.

Another theme for the preferences of the study participants was the disclosure setting. Usually, patients expect physicians to spend enough time talking to them.¹⁹ Schofield *et al.* found that patients wanted to be alone in face-to-face interaction with their doctor to hear the diagnosis.²⁰ Aminiahidashti *et al.* indicated that the bad news must be disclosed to patients in a calm and suitable place and after the routine working hours of medical centers.³⁸ Hence, Iranian patients favor receiving the bad news in a private office setting, which is peaceful and without any interruptions or distractions.³⁹

Psycho-spiritual care was the other dimension of patient preferences identified in this study. They preferred to have a visit with a psychologist/psychiatric for psycho-spiritual care after receiving bad news about their diagnosis. Research shows that providing psychotherapy and spiritual care for cancer patients and their relatives can help them better adjust to the new situation.⁴⁰ Furthermore, Iranian breast cancer patients who participated in this study preferred Islamic spiritual care as a coping strategy to help them confront and deal with bad news. Studies have shown that spirituality is an intermediary between stress and psychological adjustment to cancer.⁴¹ Therefore, considering the cultural and religious background of Iranian patients, it is highly recommended that this preference be respected.

Another dimension of the preferences of our patients was to avoid using the word "cancer." Cancer patients and their families in Asia and the Middle East prefer not to use the term "cancer" as it implies an incurable disease, and thus invokes fear, anxiety, and pain in many patients.⁴² In Iranian culture, "cancer" is a taboo and "tumor" or "malignant mass" is used instead, because it is assumed that using "cancer" destroys the patients' hopes and causes negative psychological reactions in them.⁴³ It seems vital to change the trend and encourage the use of "cancer." However, the word "cancer" or other alternatives should only be used by doctors after considering mental readiness of breast cancer patients for receiving bad news.

It must be noted that the findings of the present study may not be completely generalizable before further complementary quantitative studies. It is also recommended that cancer patients' preferences be considered in a wider range in other studies with regard to such demographical variables as age, education, and occupation.

In conclusion, to inform the patients of the bad news, and in compliance with the international protocols, physicians need to be aware of the patients' preferences regarding the way of receiving the bad news. The findings of this study could enhance the quality of doctor-patient communication



with regard to the disclosure of bad news and help patients to better cope with the news of breast cancer diagnosis. That is why it is highly essential to incorporate the Iranian patients' preferences obtained and gathered here into training programs for physicians.

Conflict of Interest

This study was supported by Tehran University of Medical Sciences (Grant No. 32452).

Acknowledgment

The authors would like to appreciate all the women with breast cancer who kindly participated in this study.

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