RESEARCH ARTICLE

Breaking bad news: a descriptive study of physicians' perspective of Sindh, Pakistan

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Abstract

Objective: To assess the perception and attitude of physicians related to breaking bad news.

Methods: The cross-sectional study was conducted at three teaching hospitals in Karachi and Mirpurkhas, Pakistan, from April 2019 to February 2020, after approval from Hamdard University, Karachi, and comprised physicians of either gender having direct patient contact. Data was collected using a questionnaire based on literature. The questionnaire was pilot-tested before distribution among the subjects. The responses were categorised with respect to age, gender and professional experience. Data was analysed using SPSS 25.

Results: Of the 230 subjects, 119(51.7%) were females. The overall mean age was 34.5±8.8 years and mean professional experience was 9.1±8.2 years. Overall, 19(8.3%) subjects believed they had a very good ability to deliver bad news, while 26(11.3%) avoided telling the patient the truth about diagnosis, prognosis and treatment. Age had a significant association with correctly defining breaking bad news ($p<0.05$).

Conclusion: The skill level related to breaking bad news was found to be deficient.

Key Words: Breaking bad news, Communication, Pakistan. (JPMA 73: 487; 2023) **DOI: 10.47391/JPMA.5249**

Submission completion date: 05-11-2021 **— Acceptance date:** 26-09-2022

Introduction

Communication skills are an integral element of medicine practice[1]. Examples of this skill in practice vary from the initial patient encounter taking medical histories to imparting a patient's diagnosis and management strategy. Examples of such diagnoses include chronic and terminal illnesses. If clinicians are not able to practice good communication skills due to a lack of training, this can lead to challenging patient interactions[2].

The subjects of breaking bad news (BBN) has been extensively researched, and dimensions vary widely across cultural contexts around the world[3-7]. There is evidence that the ability to convey news to a patient can have a significant effect on patient experience, which, in turn, can lead to improved patient outcomes[8]. One way to explain how bad news is viewed by physicians is to use the awareness, attitudes and actions paradigm.

The benefits of integrating BBN training has been documented well in studies from around the world[9]. In many countries, medical schools and hospitals require the teaching of these communication skills as part of the core curriculums[10]. Physicians also encounter this in postgraduate training[11]. However, despite options that do exist, opportunities can exist asymmetrically within cultural contexts and in resource-limited settings. Even if there are resources, the uptake will differ considerably across institutions and countries. The current study was planned to assess the perception and attitude of physicians related to BBN.

Subjects and Methods

The cross-sectional descriptive study was conducted from April 2019 to February 2020 at one public-sector and two private tertiary care hospitals in Karachi and Mirpurkhas, Pakistan, after approval from the ethics review committee of Hamdard University, Karachi. The survey was conducted outside the premises of two hospitals and only verbal consent was obtained from the participants, whereas written permission was obtained from the third institution and data was collected on the premises.

The sample was raised using non-probability convenience sampling method, and those included were physicians of either gender having direct patient contact. Data was collected using a self-administrated questionnaire developed in the light of Setting and listening skills; Patients perception; Invitation to give information; Knowledge; Explore emotions and empathise; Strategy and summarise (SPIKES)[12],

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Background; Rapport; Explore; Announce; Kinding; Summarise (BREAKS)[13] and the Calgary-Cambridge framework[14]. The questionnaire included demographic information as well as questions related to physicians' BBN knowledge, awareness and practices. The questionnaire was initially piloted with 8 participants comprising colleagues and peers to check for possible inconsistencies in question comprehension. After necessary modifications, the questionnaire was finalised and distributed among the study participants (Annexure). The sample size was calculated using Raosoft sample size calculator at 95% confidence level, 5% margin of error, and 20% expected awareness of SPIKES protocol[15]. The sample was inflated by 10% to cover for refusals or dropouts.

Data was analysed using SPSS 25. Descriptive results were tabulated as frequencies and percentages, and logistic regression model was used to assess association of responses with age, gender and professional experience. P<0.05 was considered statistically significant.

Results

Of the 243 doctors approached, 230(94.6%) participated; 119(51.7%) females and 111(48.3%) males. The overall mean age was 34.52±8.8 years, and mean professional experience was 9.1±8.2 years. The majority was associated with Medicine and allied fields 129(56%), and 154(67%) had professional experience up to 10 years. Overall, 19(8.3%) subjects said they had a very good BBN ability, while 26(11.3%) avoided telling the truth about diagnosis, prognosis and treatment to patients. Further, 11(4.8%) subjects felt insecure dealing with BBN, while 100(43.5%) felt the duty was fulfilled. A large majority

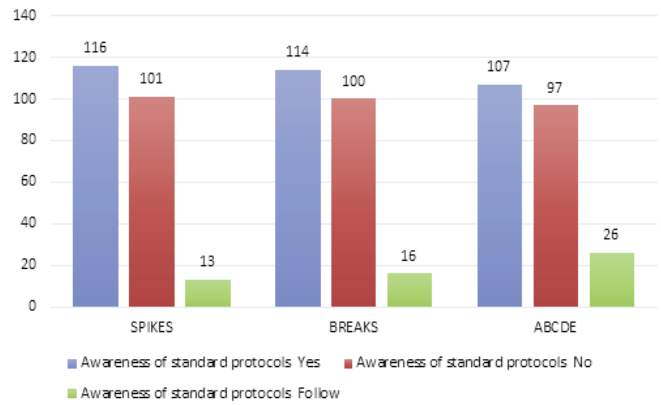

Figure: Awareness of standard protocols. SPIKES: Setting and listening skills; Patients perception; Invitation to give information; Knowledge; Explore emotions and empathise; Strategy and summarise, BREAKS: Background, Rapport, Explore, Announce, Kinding, Summarise, ABCDE: Advance preparation; Build a therapeutic relationship; Communicate well; Deal with patient and family reactions; Encourage and validate emotions.

Table-1: Demographic characteristics and participant's response to questions.

Variable	N = 230	%
Sex		
Male	111	48.3
Female	119	51.7
Age (in years)		
24–35	144	62.6
> 35	86	37.4
Mean (SD)	34.5 (± 8.8)	
Field of specialisation		
Medicine and allied	129	56.1
Surgery and allied	85	37.0
Accident and Emergency	09	3.9
Dentistry	03	1.3
Not disclosed	04	1.7
Years of Experience		
1 to 10	154	67.0
> 10	76	33.0
Mean (SD)	9.1 (± 8.2)	
Individual's ability to give bad news		
Very Good	19	8.3
Good	79	34.3
Acceptable	124	53.9
Comprehensive	8	3.5
Place of giving the bad news		
Find a private and cosy place	108	47.0
Report in an available office	77	33.5
Inform informally in the hallway/ward or some other place outside the office	45	19.6
Do you always tell the truth about diagnosis, prognosis and treatment when giving the bad news?		
Never	8	3.5
Avoid telling the truth	26	11.3
Speak everything at once	35	15.2
Carefully, carefully on the request of the patient and/or family members	161	70.0
To whom the truth is being told		
Only to the patient	2	0.9
Only to the family	41	17.8
The patients and his/her companion at the same time	32	13.9
Preferably first to the patient, then to the family	57	24.8
Preferably first to the family, then to the patient	98	42.6
Feeling about giving the bad news		
Sad	62	27.0
With pity	38	16.5
Feeling of duty fulfilled	100	43.5
Relieved	13	5.7
Insecure	11	4.8
Afraid	4	1.7
Others	2	0.9
Importance of incorporating "How to give bad news" in the curriculum		
Very Important	184	80.0
More or less important	12	5.2
Important	32	13.9

Continued

Continued

Little important	2	0.9
In case the relative wants to hide the diagnosis of a serious illness from their patients		
Agree with the relatives and avoid telling the diagnosis	103	44.7
Tell them to go to another doctor	7	3.0
Tell them: if the patient asks me, I will tell the truth	93	40.4
Disagree with the relatives and tell the diagnosis	27	11.7

184(80%) believed BBN is important enough to be incorporated in the curriculum (Table 1). Awareness level related to various standard BBN protocols was also assessed (Figure).

Bivariate logistic regression of the responses showed age was a significant predictor of defining BBN ($p<0.05$) (Table 2).

Table-2: Participants' response to questions with respect to age, gender and professional experience.

Questions	Response					
	Adequate	Inadequate	β*	*P*-value	Odds Ratio	95% CI
Defining Breaking bad news	145 (63.0%)	85 (37.0%)	β_1: -1.462	0.023	0.232	0.066, 0.816
			β_2: 0.173	0.542	1.189	0.618, 2.076
			β_3: 0.875	0.186	2.399	0.655, 8.781
Assess the patients' knowledge about their condition or situation before telling them the diagnosis	209 (90.9%)	21 (9.1%)	β_1: 0.115	0.910	1.122	0.152, 8.285
			β_2: -0.188	0.688	0.829	0.331, 2.072
			β_3: -0.129	0.903	0.879	0.110, 7.001
The patient should be told everything about their serious illness?	121 (52.6%)	109 (47.4%)	β_1: 0.668	0.271	1.951	0.594, 6.405
			β_2: -0.010	0.970	0.990	0.580, 1.688
			β_3: -0.061	0.923	0.941	0.275, 3.222
Pakistani patients do not want to know about their diagnosis and prognosis of a serious illness	67 (29.1%)	163 (70.9%)	β_1: 0.575	0.414	1.777	0.447, 7.067
			β_2: -0.515	0.087	0.597	0.331, 1.078
			β_3: -0.323	0.658	0.724	0.174, 3.022

Of the total, 193(83.9%) participants said they preferred BBN communication in clear, understandable language that avoided technical words, 152(67%) learned it from colleagues, seniors and consultants, while 173(75%) mentioned high expectation of patients or their relatives about the possible medical outcome was the biggest BBN barrier (Table 3).

Discussion

To the best of our knowledge, the current study is the first to assess the BBN perception and attitude of physicians working in tertiary care hospitals in Pakistan's southern province of Sindh.

BBN is the process of providing negative information to a person. It is an emotionally stressful situation for doctors as well as for patients and their families. To achieve patient satisfaction, it is necessary to know BBN awareness, attitudes and behaviours in medical settings among those delivering medical care to patients. This is because adequate communication training increases patient satisfaction[16]. It is critical that Pakistani clinicians develop the capacity to provide this knowledge, as the global burden of chronic diseases is increasing. These increases are similarly expressed in the developed world[17].

Previous BBN research in Pakistan remains limited. However, some literature has appeared over the last decade. This provides a contextual model for the subject[18]. The findings of Baig et al. included a general recognition of the value of presenting bad news among clinicians. The findings highlighted the need to develop the skills of Pakistani clinicians in this regard[18]. However, Jameel et al.[19] found that clinician's uptake of BBN training was low, but the study, done in 2012, may not represent the current situation. There is a need for re-evaluating the situation, which the current study tried to address.

Considering how the past may have influenced present realities, Sarwar et al.[15] found that medical residents were dissatisfied when it came to BBN, but, again, it may not be truly representative of the entire country because the study was conducted in a tertiary hospital in Lahore.

There were notable key themes that emerged in the current study. On the topic of delivering bad news, many

Table-3: Quality-of-Life (QoL) questionnaire scores reported by the patients during follow-up.

Options	Frequency	% of cases
Ways of delivering bad news		
With clear, understandable language, avoiding technical words	193	83.9
Explaining in detail	112	48.7
Establishing a trust relationship	87	37.8
Clarifying doubts	83	36.1
Putting oneself in the patient's place	46	20.0
Giving hope even that they don't exist	45	19.6
Doctors should not tell all details about poor prognosis as it will make patients/relatives depressed	18	7.8
Doctors should delay telling the patient and, in the meantime, amilies/patients recognise themselves that patient is dying	15	6.5
Fears of doctors in giving bad news		
iFear of ending patient's hope	118	51.3
Fear of their own emotional reactions	110	47.8
Fear of patient reactions	109	47.4
Fear of being blamed	76	33.0
Fear of death and disease itself	26	12.6
Source of learning to give bad news		
Observing colleague/senior or other specialists/consultants	152	66.7
During under or postgraduate studies	130	57.0
By trial-and-error method	66	28.9
Through specific courses	22	9.6
Barrier for breaking bad news		
High expectation of the outcome of the patients or their relatives	173	75.5
Fear of not knowing all the answers to the patients or the relatives' questions	68	29.7
Fear of being blamed	59	25.8
Personal fear of illness or death	44	19.2

doctors were able to correctly define it (63%). Also, only 43% respondents felt their individual BBN ability was good or better. This value is comparable to 49.5% reported earlier[15], and a marked improvement on perceived ability among 85% respondents[19]. Time since graduation was significant for perceived BBN ability ($p<0.01$), which was in contrast to literature[15].

When practising, clinicians' feelings varied, with common responses being duty fulfilled (43%), pitiful (17%) and sadness (27%). Besides, 20% respondents said BBN should be done by giving hope even if the basis for the said hope may not exist.

Different questions asked in the questionnaire focussed on different elements of knowledge, attitudes, and behaviour (KAB), and showed that clinicians were slowly gaining BBN aptitude. In addition, some behaviours reflected an appreciation of the BBN value.

In the current cohort, 29% respondents agreed that patients do not want to know a serious diagnosis. In terms of what the respondents viewed as challenges in practice, 75.5% cited high standards of care as an obstacle to BBN. Also, 25.8% subjects shared concerns that they might be blamed. This sentiment is not new in literature[18]. It may be of interest to conduct studies on patients' expectations in Pakistan. In addition, BBN training will benefit from concentrating on managing expectations to facilitate the doctor-patient interaction. Training in ethical patient communication should also be considered in the light of such findings.

Clinicians showed increased trust in practice on the subject as 57% respondents reported BBN training from their undergraduate/postgraduate studies. Another study found that 95% of its respondents had not had any training at the undergraduate level[19]. Additionally, 66.7% of respondents referred to training by observing seniors at work compared to 66% reported earlier.[19] Just 10% clinicians responded learning of skills from relevant courses. Regarding the use of protocols, only 44% and 43% of the respondents said they were aware of the SPIKES protocol and BREAKS approach, respectively. In literature, 20% knew of SPIKES and 33% knew of BREAKS[15]. Of the total, 80% respondents said it was "very important" that BBN training be included in the curriculum. This mirrors earlier findings[15].

With respect to BBN, if the relative of the patient asked to withhold the diagnosis from the patient, 45% clinicians indicated their intention to comply with such a request. In an earlier cohort, the corresponding statistics was 59.5%[15]. If the patient directly asked about the diagnosis, 40% doctors would only then provide the details. Just 12% of the respondents decided that they should always warn the patient of bad news, regardless of the family's wishes. Nevertheless, 3% said they would suggest the relative to see another doctor straightaway. This demonstrates the need to provide graduates with proper BBN training. Patients should be aware of their diagnoses, and this heterogeneity between the answers to this question is a major ethical issue, in addition to the practical concern of good communication in doctor-patient relationship.

The importance of addressing these issues is further underscored by the fact that guidance exists in countries, such as the United Kingdom, on patient details relevant to certain clinical diagnoses[20]. Considering that there are many doctors trained in Pakistan who practise abroad[21],

there is a further practical case to help standardise practice between southern Pakistan and the rest of the world.

As regards the use of protocols in practice, only 50.4% respondents said they were aware of SPIKES. This is an improved value compared to 20% and <10% reported earlier[15,19]. This improvement is seen against the backdrop of current protocols to strengthen BBN willingness of clinicians[12,15]. As a result, intensive training in these approaches as part of medical curricula and short-term courses can both provide a structure for clinicians while also improving personal perceptions on the matter. Although Pakistan's specific work on SPIKES is limited, adopting a universal approach that has evidence from elsewhere is the most feasible way to further improve these skills in the region. Once it has been developed as a standard, future work could be done to optimise the approach that is ideally moulded to the cultural context.

Although our research focused on the clinician's viewpoint on BBN in Pakistan, the patient's perspective was not addressed whereas other countries have investigated this aspect[22,23]. This is one of the limitations of the current study. Another limitation is that the sample was selected from three hospitals only, and no testing for its validity and reliability was performed.

Conclusions

The skill level related to BBN was found to be deficient. Emphasis should be on improving such skills in a resource-limited environment.

Disclaimer: None.

Conflict of Interest: None.

Source of Funding: None.

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Annexure

Breaking Bad News – Pakistani Doctor's Perspective

Questionnaire

Mark a tick or fill in the blanks as appropriate. Please attempt all questions.

1) Age: _____ (in years) 2). Sex: i) Male ii) Female

3). Department/Speciality: _____ 4). Experience after graduation (in yrs) :_____

5). How do you define **BAD NEWS?**

i) News about physical harm/life threatening disease to the patient.

ii) News of death.

iii) Any information transmitted that implies any negative change and would be capable of affecting the individual's view of life or their outlook for the future e.g., any disease

6). How often do you **deliver BAD NEWS?**

i) Less than once a month ii) 1 – 4 times a month iii) 5 – 10 times a month iv) More than 10 times a month

7). How do you consider your ability to give bad news?

i) Comprehensive ii) Very Good iii) Good iv) Acceptable

8). Where do you usually give bad news?

i) Find a private and cosy place ii) Report in an available office

iii) Inform informally in the hallway/ward or some other place outside the office

9) Do you ASK your patients whether they want to know their diagnosis of a serious illness before you tell them?

i) Yes ii) No

10) Do you assess your patients' knowledge about their condition or situation before you tell them the diagnosis?

i) Yes ii) No

11). How do you provide the bad news? **(May have more than one answer)**

i) ¬ With clear, understandable language, avoiding technical words

ii) ¬ I explain in detail

iii) ¬ I give hopes even that they don't exist

iv) ¬ I establish a trust relationship

v) ¬ I explain in detail and technical

vi) ¬ I put myself in the patient's place

vii) ¬ I clarify doubts

viii) ¬ I don't think doctors should tell all details about poor prognosis as it will make patients/relatives depressed

ix) ¬ I delay telling them and, in the meantime, families/patients recognise themselves that patient is dying

x) ¬ Any other, please specify: _____

12). When giving the bad news, do you always tell the truth about diagnosis, prognosis and treatment?

i) ¬ Never. ii) ¬ Avoid telling the truth iii) ¬ Speak everything at once.

iv) ¬ Carefully, carefully, according to the request of the patient and / or family members.

13). Do you think the patient should be told everything about their serious illness?

i) ¬ Yes ii) ¬ No iii) ¬ Not sure

14) To whom do you tell the truth?

i) ¬ Only to the patient ii) ¬ Only the family iii) ¬ The patient and his / her companion, at the same time iv) ¬ Preferably, first to the patient, then to the family

v) ¬ Preferably, first to the family, then to the patient

15) How do you feel about giving bad news?

i) ¬ sad ii) ¬ With pity iii) ¬ Feeling of duty fulfilled

iv) ¬ Relieved v) ¬ Insecure vi) ¬ Afraid vii) ¬ Others

16) What fears do you have in giving bad news? **(May have more than one answer)**

i) ¬ Fear of being blamed ii) ¬ Fear of ending the patient's hope iii) ¬ Fear of patient reactions

iv) ¬ Fear of death and disease itself v) ¬ Fear of their own emotional reactions

vi) ¬ Others: _____

17) How did you learn to give bad news **(Tick more than one answers if needed)?**

i) ¬ During under/post graduate studies ii) ¬ By trial and error method

iii) ¬ Through specific courses iv) ¬ Seeing/follow other specialists/senior or colleague

v) ¬ Any other (pl specify) _____

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18) How important do you think is incorporation of **"How to give bad news"** in the course of graduation?
i) Very important ii) More or less important iii) Important iv) Little important v) Not important
19) Do you think Pakistani patients do not want to know about their diagnosis and prognosis of a serious illness?
i) ¬ Yes ii) ¬ No iii) ¬ Not sure
20) If the relative wants to hide the diagnosis of a serious illness from their patients what will you do?
i) ¬ Agree with the relatives and avoid telling the diagnosis to the patient
ii) ¬ Tell them to go to another doctor
iii) ¬ Tell them: if the patient asks me I will tell the truth
iv) ¬ Disagree with the relatives and tell the diagnosis to the patient
v) ¬ Others, please specify_____
21) What do you see as a barrier for breaking bad news? **(May have more than one answer)**
i) ¬ High expectation of the outcome of the patients or their relatives
ii) ¬ Fear of not knowing all the answers to the patients or the relatives' questions
iii) ¬ Personal fear of illness or death
iv) ¬ Fear of being blamed
v) ¬ Others, please specify_____
22) Are you aware of the following standard protocols? Which one do you follow for breaking the bad news

SPIKES	i) ¬ No	ii) ¬ Yes	iii) ¬ Follow
BREAKS	i) ¬ No	ii) ¬ Yes	iii) ¬ Follow
ABCDE	i) ¬ No	ii) ¬ Yes	iii) ¬ Follow

Thank you for your participation