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Breaking Bad News: Jordanian Doctors' Training Needs & Applicability of Training Frameworks

Katherine C. Miles[1], Mustafa Saad Yousuf[2], Abdel-Ellah Al-Shudifat[3]

[1] Department of Pharmacology, Public Health and Clinical Skills, Faculty of Medicine, The Hashemite University, PO Box 330127, Zarqa 13133, Jordan

[2] Department of Anatomy, Physiology and Biochemistry, Faculty of Medicine, The Hashemite University, PO Box 330127, Zarqa 13133, Jordan

[3] Department of Internal and Family Medicine, Faculty of Medicine, The Hashemite University, PO Box 330127, Zarqa 13133, Jordan

*Corresponding author:

katemiles@doctors.org.uk

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Abstract

Background: Sharing bad news is a complex and challenging task for doctors, requiring knowledge and skills development.

Aims: To identify Jordanian doctors' training needs for breaking bad news, comparing two different populations of doctors, and to investigate the applicability of different training frameworks.

Methods: This questionnaire based cross-sectional study targeted doctors working at hospitals in Amman, Jordan. Data was analyzed using SPSS v25 and MedCalc v20. Comparisons were made using chi-square test. Free text responses were analyzed thematically.

Results: 161 doctors participated of whom 33.8% had received breaking bad news training. 45.5% of doctors were confident/very confident at breaking bad news. However, there was no significant association between confidence and training status. The greatest challenge reported by 64.1% of doctors was that "relatives do not want the patient to know the diagnosis" and a free-text challenge was "managing aggressive reactions of patients and/or relatives". The highest interest in training for specific skills was 59% for "answering difficult questions". Comparison between doctors working at a specialized cancer hospital and those working at government hospital revealed statistically significant differences in the frequency of breaking bad news ($p = .031$), attendance of training ($p = .010$), and helpfulness of training ($p = .001$).

Conclusions: Combining elements of different international communication skills models and taking into account specific cultural considerations may provide the most culturally responsive curriculum framework for developing the skills of current and future Middle Eastern doctors.

Keywords: Breaking bad news; communication skills; medical education; Middle East; physicians.

INTRODUCTION

Breaking bad news (BBN) to patients is considered one of the most complex and difficult communication tasks that a doctor undertakes [1]. Buckman defined bad news as "any information likely to alter drastically a patient's view of her or his future" [2]. The skill of communicating bad news can greatly affect a patient's experience, with poor communication leading to worse clinical and psychological outcomes [3]. Therefore, it is important that bad news is communicated in

a careful and logical manner with appropriate use of both verbal and non-verbal communication skills [4].

Models for Breaking Bad News

In the United Kingdom (UK) and the United States of America (USA), communication skills training programs for BBN are commonly offered to medical trainees. Models or strategies can assist in developing trainees' capabilities to break bad news, for example, the SPIKES strategy, proposed by Baile et al. [1] suggested consideration of the *Setting, Perception, Invitation, Knowledge, Emotions and Strategy*, to guide these conversations (Appendix 1). Another commonly used model for the medical consultation is the Calgary-Cambridge Framework [4] and skills for BBN which included: preparing the environment, establishing rapport, giving a warning, providing the correct amount of information, using easily understood language, allowing pauses, displaying empathy, using appropriate physical touch, checking the patient's understanding, answering questions, shared decision making, relating the diagnosis to the patient's perspective and planning follow up [4].

Despite these frameworks being over fifteen years old, they continue to inform many BBN communication skills programs throughout the UK [5]. These frameworks have been developed from research in predominantly Western populations and yet with increasing globalization and migration of people between countries, it is important to discover how relevant and applicable these strategies are in different cultural contexts. Grant [6] suggested that "effective education must be contextual" but currently there is limited published research from the Middle East investigating the effectiveness of these strategies for BBN to meet doctors' training needs. In our context in Jordan, Salem and Salem [7] suggested a dynamic framework of "patient-led disclosure" developed from published literature and personal experience. The IGAD framework (Table 1) is contextualized for the Middle East and highlights additional dimensions which are not explicit as part of the SPIKES or Calgary-Cambridge frameworks. However, the IGAD framework has not been evaluated in practice.

Table 1. IGAD Framework proposed by Salem and Salem[7]

Letter	Component	Details
I	Interview	Ask the patient if they would like relatives present and facilitate this
G	Gather	Gather information on the desired level of disclosure a patient wants
A	Assess, Achieve	Assess religious and family influences Achieve rapport
D	Decide Disclose Discuss	Decide on the appropriate level of disclosure Disclose information slowly and simply Discuss and summarize

Situation in Jordan

Doctors' attitudes towards and practices of BBN to patients in Jordan have not been widely researched. A few studies investigated truth telling practices of doctors in Jordan [8-10]. These studies gave an indication of the complexities regarding BBN

to patients and the strong influence of socio-cultural factors in the Middle East. To our knowledge, there is no nationwide policy in Jordan requiring doctors to disclose health information to patients. Individual Jordanian institutions may lack guidelines for truth disclosure [9]. There is only one specialized hospital for cancer treatment, the King Hussein Cancer Center (KHCC), which has a policy of disclosing the diagnosis to patients prior to treatment (unless a patient specifies otherwise). In contrast, doctors working in government hospitals are not obligated to inform patients of their diagnosis.

Teaching and training of BBN is not systematic in Jordan and only one university included an experiential teaching module focused on BBN for medical students. There is no central organization of postgraduate training in Jordan, so professional development courses for BBN are institution dependent.

The aim of this research is to identify Jordanian doctors' training needs for BBN and to compare two different populations of doctors, those working at a specialized cancer hospital and those working in a general hospital. The results of this research will increase understanding about the applicability of BBN frameworks in a non-Western context.

METHODS

With a pragmatist theoretical perspective, we used a cross-sectional survey design, integrating both closed-ended and open-ended questions, to address the study aims. We identified two hospital sites in Jordan for data collection, King Hussein Cancer Center (KHCC), a specialist cancer hospital, and Prince Hamza Hospital (PHH), a general hospital. The Ministry of Health ethics committee granted ethical approval (333/32/HM).

We used a cross-sectional convenience sampling technique to collect data from doctors at KHCC (n = 315) and PHH (n = 190) during the time period November 2016 – January 2017. Doctors did not disclose their names, so their responses were anonymous. Doctors participated voluntarily, and their decision to participate did not affect the care of patients. All participants gave written informed consent. No specific exclusion criteria were used.

Questionnaire Development

We developed a bespoke paper-based questionnaire (Appendix 2), informed by the published literature [11-12] and aligned with skills associated with BBN frameworks. The questionnaire was written in English, as throughout Jordan the language of instruction for medicine is English. The questionnaire was reviewed by three medical doctors, to support sequencing and content validity. We piloted the questionnaire with ten participants to check the survey design, comprehension and appropriateness of questions and time taken to complete the questionnaire. In response, we omitted a question about ethnicity that participants advised could cause potential emotional distress to respondents, due to political and historical factors in the region.

Data Analysis

We analyzed the quantitative data using descriptive and inferential statistics. We reported the results as percentages and made comparisons with chi-square test using IBM SPSS v25 and MedCalc v 20. We analyzed the qualitative data using thematic analysis [13] and included verbatim quotes to promote credibility of the results [14].

RESULTS

Doctors' Demographics

A total of 161 doctors responded to the survey. Of the participating doctors, 51 (31.7%) were from KHCC, 109 (67.7%) were

from PHH and one doctor indicated a third hospital as their workplace (0.6%). The one doctor who indicated that they worked in a third hospital must have been temporarily working at either KHCC or PHH to receive and submit the questionnaire. Various demographics of the doctors were considered, including gender, age group, specialty, and experience (refer to Appendix 3 for details). Using chi-squared test, it was found that the sample of doctors was not homogeneously distributed between the various categories of these demographics (Table 2).

Table 2. Various demographics considered for the doctors, category with most frequency, and chi-squared test for homogeneity of distribution of sample in the various categories.

		Chi-squared test		
Criteria	*Category with highest frequency, n (%)*	***value***	***n, df***	***p***
Gender	Male, 131 (81.4%)	63.360	161, 1	< .001
Age group	25-34 years, 89 (55.3%)	217.596	161, 5	< .001
Specialty	Internal Medicine, 46 (28.6%)	217.130	161, 12	< .001
Experience	1-5 years, 60 (38%)	118.835	158, 5	< .001

Breaking Bad News Experiences and Training Needs

When asked about the various conditions the doctors considered as "bad news", cancer was chosen the most by 146 doctors (91.3%, n = 160). Amputation came out second with 111 choices (69.4%, n = 160).

Training for BBN had been undertaken by 52 of the responding doctors (33.8%, n = 154). Training time ranged between 2 and 50 hours (mean = 9, SD = 9.86). When asked about type of training and the level of taking the training, "lectures" was the most common form (Table 3), and most training occurred 'during practice'. Forty-nine of the doctors who received training gave their degree of satisfaction with the training: 10 were very dissatisfied/dissatisfied, 22 were neutral, and 17 were satisfied/very satisfied. On the other hand, 83 doctors (55.3%, n = 150) thought that a 'workshop' was the most beneficial type of training for BBN, even though only 15 doctors had had the opportunity to participate in a workshop.

Table 3. Frequency of doctors that have taken various types of breaking-bad-news training at different levels.

	Level		
Type of Training	*Undergraduate*	*Postgraduate*	*During Practice*
Lecture	22	11	13
Seminar	11	12	11
Role-play	6	8	9
Workshop	2	6	7
Conference	1	3	3
Online course	1	6	8
Books / articles	7	10	11

About 34.2% of the doctors (54, n = 158) broke bad news monthly and 31.6% (50, n = 158) did so weekly. When asked how confident they were in delivering the bad news, 154 participants answered, with 22 (14.3%) being very unconfident/unconfident, 62 (40.3%) being neutral, and 70 (45.5%) being confident/very confident. By using these three categories of confidence and employing chi-squared test, no significant effect of training status was found on the doctors' confidence in delivering bad news, X^2 (2, n = 147) = 2.530, p = .282.

Many challenges may face the doctor when giving bad news. The challenge "Relatives do not want the patient to know the diagnosis" was chosen the most by 100 doctors (64.1%, n = 154). Other challenges asked about in this research are shown in Figure 1. A further challenge expressed by doctors, from the free text comments, was around managing a verbally or physically aggressive response of patients and/or relatives to the news, *"After any Cardio-Pulmonary Resuscitation relatives don't accept the news if it failed; they started fighting and broke down everything [breaking the equipment]."* (Participant-11) and one doctor noted a skills gap, *"... to protect myself against possible violence when giving bad news."* (Participant-36).

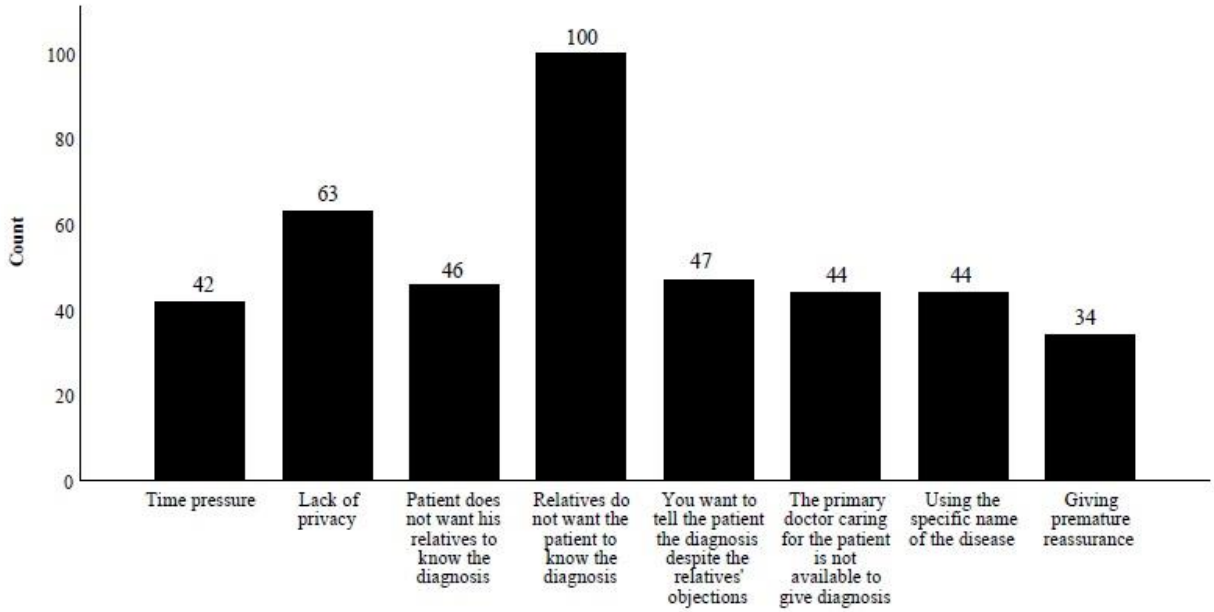

Figure 1. Challenges that may face a doctor when giving bad news and the number of doctors that chose each challenge.

Using five-point Likert items ranging from very uninterested to very interested, the doctors were asked to rate their perceived need for further training in 14 specific skills related to BBN. The results are shown in Figure 2. The percentage of doctors who felt neutral about further training in specific skills ranged between 25% - 39%. Despite this important percentage, the percentage of doctors who were interested/very interested was higher than those who were uninterested/very uninterested in all the

suggested skills training. The highest percentage of doctors who were interested/very interested was 59% for the "Answering difficult questions" skill, followed closely by "Checking patients' understanding" at 58% and then "Using religious phrases appropriately" at 55%. The largest percentage of doctors who were uninterested/very uninterested was 30% for the "Explaining bad news in different languages" skill which was coupled with the lowest percentage that were interested/very interested at 34% (Figure 2).

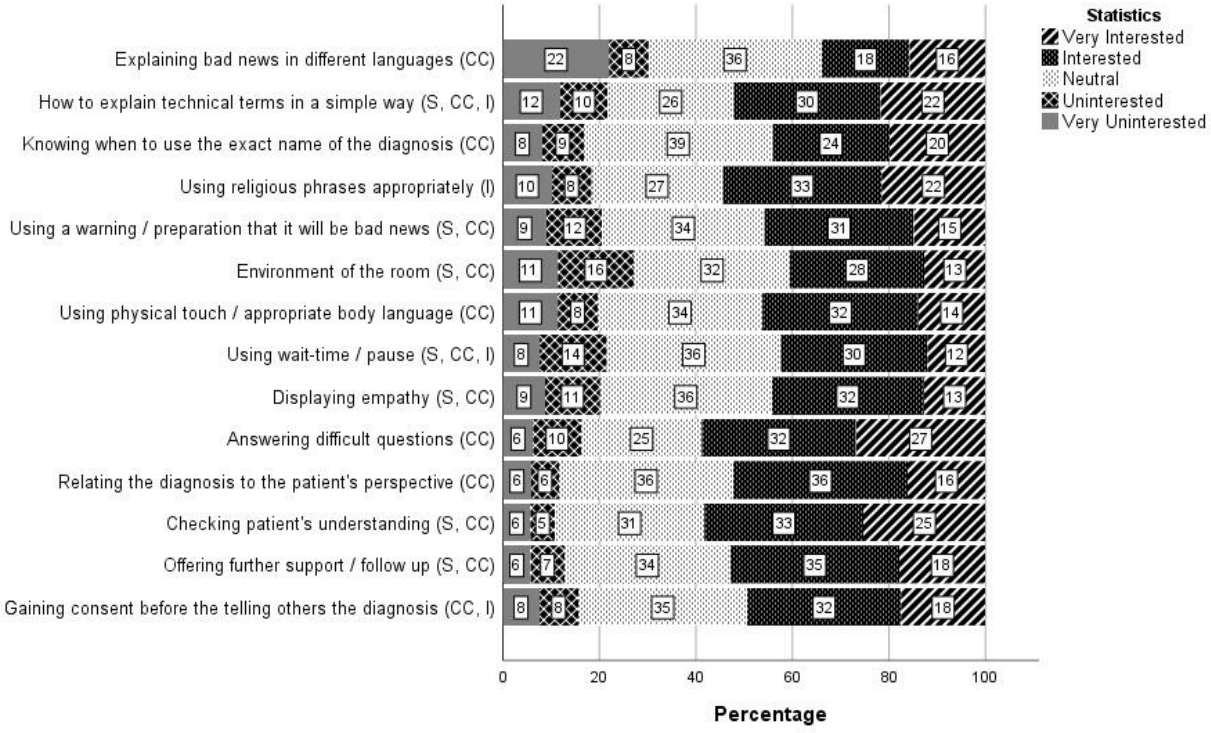

Figure 2. The perceived need of doctors, expressed as percentages, for further training in 14 specific skills related to breaking bad news.

Key: S – skill component of the SPIKES framework, CC – skill component of Calgary-Cambridge Framework, I – skill component of the IGAD framework

Comparison of Doctors' Training Needs Between Two Hospitals

The survey responses from KHCC and PHH were compared, the difference in participation between KHCC and PHH was significant, X^2 (1, n = 160) = 21.025, $p < 0.001$. According to the research aims, the questions shown in Table 4 were further analyzed (with X^2 test using MedCalc v20) to compare the responses of the doctors from the two different hospitals across the various categories of these questions. How often doctors from these two hospitals broke bad news was significantly different, with most doctors (32%) from KHCC giving bad news weekly; while most doctors (36%) from PHH broke bad news monthly. When asked if they were trained in BBN, 47% (n = 24) of doctors in KHCC answered "Yes"; compared to 26% (27) from PHH. The training was helpful for 91% (21) of KHCC doctors and 44% (21) of PHH doctors. For these two questions, the

differences were significant (Table 4). When asked about training satisfaction, however, no significant difference was found between the answers of the doctors from the two hospitals (three categories were used: very dissatisfied/ dissatisfied, neutral, satisfied/very satisfied). In addition, no significant difference was found between the confidence of the doctors in the two hospitals in breaking bad news (categories used were: very unconfident/unconfident, neutral, confident/very confident).

Table 4. Comparison between KHCC and PHH doctors' experiences and helpfulness of various BBN criteria.

Question	Response Category	n		X^2 test		
		KHCC	PHH	Value	df	p
Approximately how often do you give "bad news" to patients or relatives?	Daily	9	13	***10.671***	***4***	***0.031***
	Weekly	16	33			
	Monthly	15	39			
	Yearly	4	20			
	Never	6	2			
Have you received any training in giving "bad news" to patients and relatives?	Yes	24	27	***6.648***	***1***	***0.010***
	No	27	76			
If you received training in giving "bad news", was this training helpful to you?	Helpful	21	21	***14.573***	***2***	***0.001***
	Don't know	1	11			
	Not helpful	1	16			
If you received training in giving "bad news", how satisfied were you with the training?	Very Satisfied / Satisfied	10	10	1.477	2	0.478
	Neutral	19	25			
	Dissatisfied / Very Dissatisfied	13	25			
How confident do you feel in giving "bad news" to patients and relatives?	Very Confident / Confident	23	46	2.425	2	0.297
	Neutral	17	45			
	Unconfident / Very Unconfident	10	12			

DISCUSSION

The findings of this study gave insight into the breaking bad news practices and training needs of Jordanian doctors. Approximately one third of Jordanian doctors in the hospitals studied broke bad news to patients weekly, indicating that breaking bad news occurs commonly in medical practice. Developing

doctors' knowledge and skills for this routine, yet complex task of BBN, is required. Although participants had most often received training through 'lectures', the preferred method for training was a "workshop". This suggests that doctors recognize the value of developing their knowledge and skills for BBN through experiential interactive training, which is commonly used in Western contexts, coupled with reflection and structured feedback to facilitate learning [15]. Published research indicated that simulation education and student-centered experiential training lead to increased knowledge and self-confidence [16-17]. In contrast, the present study demonstrated no significant effect of doctors' training status on confidence for BBN and only 34.7% of doctors who received training were satisfied/very satisfied with the training. This indicated a need to provide high quality training programs that lead to tangible effects and improvements in practice. Also, there is a need to introduce training more widely starting from undergraduate level, as most doctors reported receiving BNN training 'during practice'.

Participants of this study recognized managing the request to withhold information as a learning need, which is not generally included in Western models for BBN. This issue has been highlighted in the literature from other Middle Eastern countries, with 80-100% of patients not wanting information about bad news to be withheld from them [18-19] and yet, in the Jordanian study by Borgan et al.[9], 54% of doctors reported that they would withhold information from the patient at the request of the relatives. Managing the request to withhold information from the patient is not as commonly encountered in Western individualistic societies because patient information is viewed as belonging to the patient, and patient consent is required before telling others [20]. However, in Middle Eastern collectivist societies, patient information is regarded as belonging to the group and, therefore, information may be withheld from the patient at the group's request [21]. This learning need will require detailed exploration within a training program to enable doctors to fully understand and apply appropriate ethical principles in a patient-centered manner. The IGAD Framework (Table 1) contains helpful components that prompt doctors to discover patient preferences regarding first disclosure and appropriate degree of disclosure or withholding of information [7].

This study identified the perceived desire for further training in specific communication skills incorporated in communication frameworks. The skills that doctors were most interested in for further training related to good knowledge transmission and fostering understanding between the doctor and the patient, for example the skills of "answering difficult questions" and "checking patients" understanding'. The latter skill is included in both the SPIKES and Calgary-Cambridge frameworks, whilst the former is included in the Calgary-Cambridge framework. Ensuring appropriate knowledge transmission and understanding is essential to support patients in the consultation and facilitates shared decision-making. Obeidat and Khrais [8] found that 48% of Jordanian oncology doctors usually use a shared decision-making approach and 68% are comfortable using shared decision-making. However, our results indicated that doctors may benefit from further training to enable them to adopt a shared decision-making approach.

Ascertaining the importance of

patients'/relatives' faith and using religious phrases appropriately was a training need which is not found in the SPIKES or Calgary-Cambridge frameworks. However, it is highlighted in the IGAD Framework [7]. The majority of people in Middle Eastern countries follow the Islamic faith and hence the use of religious phrases may be helpful in the context of BBN [22]. Similarly, a large cross-sectional survey in Saudi Arabia found that 54% of the general public would prefer the use of religious phrases when receiving bad news [23]. Therefore, it appears necessary to include learning points about the use of religious phrases as part of BBN curricula/training in Jordan.

From the free text themes, doctors identified the learning need to manage aggressive reactions of patients and/or relatives. This element within BBN has not been highlighted in the published literature from either Western or Middle East contexts, although the skill of "displaying empathy" found in the SPIKES and Calgary-Cambridge frameworks may be helpful to prevent the build-up of an aggressive reaction. It can be noted that some people from an Arab culture can react in a more overtly emotional manner to situations when compared to people from Western cultures [24]. Middle Eastern culture expects outbursts of emotional behavior in response to death [24]. Recent news publications raised the issue of doctors in Jordan and Iraq being assaulted by angry patients and/or relatives after delivering bad news [25-26]. Training doctors in how to manage and support those who feel angry or respond in an aggressive manner may be important.

The comparison of doctors working at the specialist KHCC with doctors working at the general PHH gave some interesting results. As expected, KHCC doctors break bad news to patients more frequently than PHH doctors, since KHCC doctors work in a specialist cancer hospital and will encounter patients with cancer diagnoses more frequently. Also, KHCC doctors received more BBN training than PHH doctors. The reason for this may be that KHCC is more likely to provide specific BBN training opportunities to doctors who work there, or that KHCC doctors may personally recognize BBN as a training need and seek out appropriate training offered by other institutions. KHCC doctors were significantly more likely to find the training that they had received helpful compared to PHH doctors and yet, there was no statistically significant difference in satisfaction with training. The reasons for this were not explored in this research, however it may be that the training was more applicable to the work of KHCC doctors.

There was no significant difference in doctors' confidence levels for BBN between the KHCC doctors and PHH doctors, even though PHH doctors broke bad news less frequently and had received less training. In Western contexts, doctors reported difficulties distinguishing between confidence and competence [27]. Additionally, some studies showed that there was no relationship between self-reported confidence and actual competence [28]. Doctors who are least skilled and most confident often have the lowest accuracy of self-assessment [29]. Therefore, PHH doctors may be giving an inflated rating of their confidence and desiring to portray increased competence. Cultural factors from the Middle East may also play a role in self-reported confidence, as reputation is an important attribute to attain and maintain. People usually present a more confident and competent self-image that they feel is more

prestigious [24].

This study highlights for the first time BBN training needs for Jordanian doctors and the findings may be applicable to doctors in other contexts who break bad news to Middle Eastern patients. There is a need to provide high quality BBN training workshops through all levels of medical education. The SPIKES, Calgary-Cambridge and IGAD frameworks all contain components that are applicable when breaking bad news to Middle Eastern patients. Combining elements from these frameworks and including specific focus on points raised in this research may provide the most comprehensive training to meet Jordanian doctors' needs.

Limitations

The small sample size and restricted locations for data collection may limit the generalizability of the study findings. Also, the sample of doctors was not homogeneously distributed across demographic categories so the study sample may not be fully representative of the population. Use of a questionnaire with mostly closed-ended questions limited discovering the reasons for certain results and further qualitative research could explore in greater depth some of this study's findings.

CONCLUSION

This study highlights the need to identify and understand specific cultural considerations when developing BBN curricula. For the Middle Eastern context, combining elements of different communication skills models and taking into account specific considerations, such as how to manage aggressive responses to bad news, may provide the most appropriate curriculum framework for developing the skills of current and future doctors.

Research was conducted at two hospitals in Jordan, one was a government hospital and the other was a cancer center.

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Declarations

Funding

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Conflicts of Interests

The authors declare no conflicts of interests.

Ethics Approval and Consent to Participate

The study did not include interventions on human subjects and voluntary informed consent to participate was obtained by participants signing a consent form. The research was carried out in accordance with the Code of Ethics of the Declaration of Helsinki.

Availability of Data and Material

The datasets generated and analyzed during the current study are available in the Mendeley Data Repository.

Authors' Contributions

KM was the main contributor for the project design and writing the manuscript. AA was the main contributor in data collection. MS was the main contributor in data analysis. All authors contributed to, read and agreed the final manuscript.

Supplementary Material

Details of the SPIKES strategy for breaking bad news can be accessed as supplementary material in Appendix 1. The questionnaire can be accessed in Appendix 2. Demographic details of doctor participants can be accessed in Appendix 3.

Appendices

Appendix 1 – SPIKES Strategy

Table A1. SPIKES Strategy (modified from Baile et al. [1])

Letter	Component	Details
S	Setting	Preparation of physical setting and mental preparation prior to consultation
P	Perception	Discover the patient's prior knowledge
I	Invitation	Find out what the patient would like to know and how they want to be told
K	Knowledge	Give a warning and give the information to the patient
E	Emotion	Respond to the patient's emotions, display empathy
S	Strategy	Make a follow up plan and summarize the conversation, check patient's understanding

Appendix 2 – Questionnaire

Doctor Questionnaire – Perspectives on Breaking Bad News

Thank you for being willing to complete this questionnaire. By completing this questionnaire, you are giving consent for your responses to be used for the purpose of this research, as described in the Participant Information Sheet. Please tick the relevant answer.

General Information

1) Gender: □ Male □ Female

2) Age: □ 18 – 24 □ 25 – 34 □ 35 – 44 □ 45 – 54 □ 55 – 64 □ 65 & older

3) Which hospital are you currently working in?

□ King Hussein Cancer Center
□ King Hussein Medical Center
□ Prince Hamza Hospital
□ Other Hospital (please specify) _____

4) What is your medical specialty?

□ Family Medicine
□ Internal Medicine
□ Obstetrics and Gynaecology
□ Paediatrics
□ Surgery
□ Other (please specify)_____

5) How many years have you been working as a medical doctor?

□ 1 – 5 □ 6 – 10 □ 11 – 20 □ 21 – 30 □ 31 – 40 □ More than 40

Information About Breaking Bad News

6) Which of the following diagnoses do you consider to be "bad news" for a patient? (tick all that apply)

- ☐ Amputation
- ☐ Cancer
- ☐ Cardiac failure
- ☐ Diabetes
- ☐ Genetic disorders
- ☐ Thyroid disease
- ☐ Other (please specify)_____

Please Turn Over

7) Have you received any training in giving "bad news" to patients and relatives?

☐ Yes ☐ No ☐ Don't know

a) If yes, what type of training have you received? At what level?

Type of Training	Undergraduate	Postgraduate	During Practice
Lecture			
Seminar			
Role-play			
Workshop			
Conference			
Online course			
Read books / articles			
Other (please specify)			

b) Please give the approximate number of hours training that you have received

_____

8) If you received training in giving “bad news”, was this training helpful to you?

□ Yes □ No □ Don't know

Why?_____

_____

9) How satisfied are you with the amount of training you have received in giving “bad news” to patients and relatives?

□ Very Dissatisfied □ Dissatisfied □ Neutral □ Satisfied □ Very satisfied

10) How confident do you feel in giving “bad news” to patients and relatives?

□ Very Unconfident □ Unconfident □ Neutral □ Confident □ Very confident

11) Approximately how often do you give “bad news” to patients or relatives?

□ Daily

□ Weekly

□ Monthly

□ Yearly

□ Never

12) What are the challenges that you face when giving bad news? (tick all that apply)

□ Time pressures

□ Lack of privacy

□ Patient does not want his relatives to know the diagnosis

□ Relatives do not want the patient to know the diagnosis

□ You want to tell the patient the diagnosis despite the relatives' objections

□ The primary doctor caring for the patient is not available to give diagnosis

□ Using the specific name of the disease

□ Giving premature reassurance

□ Other (please specify)_____

13) What type of training about giving “bad news” would you find most beneficial?

- ☐ Lecture
- ☐ Seminar
- ☐ Role-play
- ☐ Workshop
- ☐ Conference
- ☐ Online course
- ☐ Reading books / articles
- ☐ Other (please specify)_____

14) Please rate your perceived need for further training in the following specific skills, related to breaking bad news:

Topic	Very Uninterested		Neutral		Very Interested
Explaining bad news in different languages	1	2	3	4	5
How to explain technical terms in a simple way	1	2	3	4	5
Knowing when to use the exact name of the diagnosis	1	2	3	4	5
Using religious phrases appropriately	1	2	3	4	5
Using a warning / preparation that it will be bad news	1	2	3	4	5
Environment of the room	1	2	3	4	5
Using physical touch / appropriate body language	1	2	3	4	5
Using wait-time / pause	1	2	3	4	5
Displaying empathy	1	2	3	4	5
Answering difficult questions	1	2	3	4	5
Relating the diagnosis to the patient's perspective	1	2	3	4	5
Checking patient's understanding	1	2	3	4	5
Offering further support / follow up	1	2	3	4	5
Gaining consent before the telling others the diagnosis	1	2	3	4	5

15) Do you have any other specific training needs?

_____

_____

_____

_____

16) Please give a description of a memorable or challenging experience of breaking bad news that you have experienced:

_____

_____

Any other comments:

_____

_____

_____

_____

_____

Thank you very much for your time in completing this questionnaire

Please return to *** or give to the Hospital Receptionist

Appendix 3 – Doctor Demographics Details

Frequency of doctors according to the various criteria considered in the research

Criteria	n	Criteria	n
Gender	**161**	***Specialty***	**161**
Male	131	Family Medicine	2
Female	30	Internal Medicine	46
Age	**161**	Obstetrics and Gynecology	3
18-24	4	Pediatrics	21
25-34	89	Surgery	40
34-44	45	Anesthesia	17
45-54	9	Orthopedics	12
55-64	10	ENT	5
65+	4	GP	2
Experience	**158**	Dermatology	4
1-5	60	Ophthalmology	1
6-10	54	Radiology	5
11-20	25	Cardiology	3
21-30	8		
31-40	9		
> 40	2		

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الافصاح عن الاخبار السيئة: احتياج الاطباء في الاردن الى التدريب و ملائمة الاطر التدريبية

كاثرين مايلز [1]، مصطفى سعد يوسف [2]، عبد الاله شديفات [3]

[1] قسم علم الادوية والصحة العامة والمهارات السريرية، كلية الطب، الجامعة الهاشمية. صندوق بريد 330127، الزرقاء 13133، الاردن

[2] قسم التشريح والانسجة وعلم وظائف الاعضاء والكيمياء الحيوية، كلية الطب، الجامعة الهاشمية. صندوق بريد 330127، الزرقاء 13133، الاردن

[3] قسم الامواض الباطنية وطب الاسرة، كلية الطب، الجامعة الهاشمية. صندوق بريد 330127، الزرقاء 13133، الاردن.

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الملخص

الخلفية والاهداف : يعد مشاركة الأخبار السيئة مع المريض مهمة معقدة ومليئة بالتحديات بالنسبة للأطباء، وتتطلب تطوير المعرفة والمهارات.وتحديد احتياجات الأطباء الأردنيين للتدريب على مهارات الافصاح عن الأخبار السيئة، مقارنة مجموعتين مختلفتين من الأطباء، والتحقق من مدى إمكانية تطبيق أطر التدريب المختلفة.

منهجية الدراسة : استهدفت هذه الدراسة المقطعية القائمة على الاستبيان الأطباء العاملين في المستشفيات في عمان، الأردن. تم تحليل البيانات باستخدام SPSS v25 و MedCalc v20 وتم إجراء المقارنات باستخدام اختبار كاي سكوير. تم تحليل الردود النصية الحرة موضوعيا.

النتائج: شارك 161 طبيبًا وتلقى 33.8% من المشاركين تدريبًا على الافصاح عن الأخبار السيئة. كان 45.5% من الأطباء واثقين/واثقين جدًا في ابلاغ الأخبار السيئة على الرغم من عدم وجود ارتباط كبير بين الثقة وحالة التدريب. كان التحدي الأكبر الذي أبلغ عنه 64.1% من الأطباء هو أن "الأقارب لا يريدون أن يعرف المريض التشخيص". ومن النصوص الحره، ابلغ المشاركون عن تحدي "التعامل مع ردود الفعل العدوانية للمرضى و/أو الأقارب". أعلى نسبة اهتمام بالتدريب على مهارات محددة كانت 59% لمهارة "الإجابة على الأسئلة الصعبة". كشفت المقارنة بين الأطباء في مستشفى متخصص للسرطان ومستشفى حكومي عن فروق ذات دلالة إحصائية في عدد مرات تكرار الافصاح عن الأخبار السيئة ($p = 0.031$)، وحضور التدريب ($p = 0.010$)، ومدى فائدة التدريب ($p = 0.001$).

الاستنتاجات: إن الجمع بين عناصر نماذج مهارات الاتصال العالمية المختلفة، مع الأخذ في الاعتبار اعتبارات ثقافية محددة، قد يوفر إطار المنهج الدراسي الأكثر استجابة ثقافيًا لتطوير مهارات الأطباء الحاليين والمستقبليين في الشرق الأوسط في الافصاح عن الاخبار السيئة.

الكلمات الدالة: الافصاح عن الاخبار السيئة، مهارات التواصل، التعليم الطبي، الشرق الاوسط، اطباء.