Disclosing bad news to patients with life-threatening illness: Differences in attitude between physicians and nurses in Israel

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Abstract

Scant attention has been paid to the decision-making process of caregivers in disclosing bad news to patients. The purpose of this study was to describe factors influencing this process and to ascertain whether physicians and nurses behave differently, based on Ajzen and Fishbein's (1980) theory of reasoned action (TRA). In this correlational quantitative research study, a validated anonymous questionnaire was administered to a convenience sample comprising 100 physicians and 200 nurses employed in several Israeli hospitals. The results indicate that only around 30% of physicians always disclosed bad news in the past, and that future decisions would be made on an individual basis. In contrast, more than 76% of nurses said that they would disclose bad news to their patients in the future. Caregivers find it difficult to disclose terminal status information to all types of patients, although most find it relatively easier in the elderly. TRA may help to predict disclosure of bad news by physicians and nurses. Behavioural beliefs, subjective attitudes and prior clinical experience with disclosure of bad news were the main factors influencing caregivers' disclosure. The main predictors among nurses were behavioural beliefs and prior experience, and among physicians were subjective norms and prior experience.

Key words: Attitudes ● Bad news ● Behavioural beliefs ● Caregivers ● Disclosure ● Theory of reasoned action

Effective and appropriate communication between patients and caregivers contributes to reducing patients' distress, and therefore significantly influences the achievement and maintenance of optimal quality of care. A problematic factor that might interfere with efficient communication is the disclosure of bad news. 'Bad news' is defined as a notification in which caregivers disclose to patients the existence of a severe condition, invoking threats to their mental or physical existence, a chance of significant disturbance of their future lifestyle, and even a high risk of death (Ptacek and Eberhardt, 1996).

For centuries, physicians avoided disclosing bad news to patients, based on the following sentence in the Hippocratic Oath: 'I will keep my patients from harm and injustice.' Physicians' customarily interpreted this as meaning that, in some cases, bad news would cause harm and shorten patients' lives (Buckman, 1996).

The Israel Patients' Rights Act of 1996 completely changed this state of affairs. The Act stated that medical care may be provided to patients only if they give informed consent. It also stated that, in order for patients to receive informed consent, caregivers must provide patients with information about their diagnosis and prognosis, even if these involve bad news. However, there is still a safeguard stating that caregivers may avoid disclosing certain information to patients if the ethics committee has confirmed that disclosing the information might cause severe harm to the patient's physical or mental health.

Disclosing bad news to patients is not the exclusive domain of physicians, and in practice other members of the interdisciplinary team may take part in this process. Often, after receiving information from physicians, patients may appeal to nurses for additional explanation of the information received (Dewar, 2000). Like physicians, nurses must adhere to the Patients' Rights Act, and to the ethical code of Israeli nurses (National Association of Nurses in Israel, 1994), which requires nurses to uphold patients' right to receive information about their condition, be what it may.

The literature on the topic of bad news was initially based only on cancer patients: the majority of studies were conducted on patients with early stage cancer, mostly in Australia or the USA. These studies showed that most patients want to be given prognostic information and rate this information as both important to them and necessary (Lobb et al, 2001; Marwit and Datson, 2002). However, one qualitative study found that patients did not want to be told a bad prognosis (Benson and Britten, 1996), and another study, involving hospitalized patients with acute myeloid leukaemia, found that many did not want their doctor to be specific about the prognosis (Friis et al, 2003).

According to Lin et al (2003), there is considerable variability in the reported rate of cancer diagnosis disclosure across studies and countries: rates of disclosure vary from 15% to 84% in countries such as Australia, Greece, Italy,

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Japan, Spain, Taiwan, Turkey and the UK (Cooper, 2001; Gattellari et al, 2002; Lin et al, 2003). These disclosure rates tend to belie patient preference for disclosure. It is important to note that information about patients' desire for disclosure in the developing world is limited (Cooper, 2001). However, the importance of the subject is now recognized by caregivers of several professions who treat patients with a variety of non-cancer, life-shortening maladies. Nevertheless, there has been no exploration of the factors affecting caregivers' decisions whether to disclose bad news to patients, and whether there is a difference in the decision-making process between physicians and nurses.

The present study examined these issues in more detail, using a model based on the theory of reasoned action (TRA) developed by Ajzen and Fishbein (1980). According to the TRA, there are two types of beliefs: behavioural beliefs and normative beliefs. Behavioural beliefs are an individual's assumption that a certain behaviour will lead to certain results. In other words, the individual assumes that if he acts in a certain way this will have certain results, to which he attributes a certain value. Normative beliefs reflect the individual's subjective evaluation (i.e. belief) of how 'significant others' would wish him to act in order to perform or avoid a specific behaviour, considering his motivation to act as they wish him to.

Individuals' intention to act in a certain manner is affected by two main factors: their attitude towards the behaviour – a personal component – and subjective norms, which reflect social leverage. Behavioural attitudes stem from the individual's judgment as to whether performing the behaviour would be 'good' or 'bad' for him. Attitudes are therefore a function of individuals' beliefs concerning the personal results expected to follow from realization of their intentions. This subjective norm is the individual's personal perception of the positive or negative social pressures exerted on him to perform or avoid a certain behaviour. A person who believes that 'significant others' support a certain behaviour will perceive the social pressures as supporting the behaviour, and vice versa. Thus the subjective norm applies pressure facilitating performance or avoidance of the behaviour independently of the individual's attitude towards this behaviour.

Behavioural intention is defined as the individual's subjective probability of performing a specific behaviour. The intention of an individual to perform (or avoid) a certain behaviour is the determinant of his behaviour. In other words, the only predictor of a behaviour is behavioural intention. Theoreticians emphasize that intention is the immediate cause of performing a certain behaviour, if it does not change before the actual behaviour is observed. The target behaviour is the response that we are interested in predicting or changing.

The study examines the process by which caregivers deliberating whether to disclose bad news to patients reach a behavioural intention. Characteristics of the caregiver, the patient and the illness are evaluated, in an attempt to clarify the relative weight of each with regard to the decision whether to disclose bad news.

The research hypotheses are:

1. Prior experience of physicians and nurses in disclosing bad news affects their future intention to disclose bad news.
2. The model of reasoned action can help to predict the behaviour of physicians and nurses in the disclosure of bad news.

'There has been no exploration of the factors affecting caregivers' decisions whether to disclose bad news to patients'

Methods

This correlational quantitative study used a convenience sample of 100 Israeli physicians and 200 nurses working in several Israeli hospitals. Two questionnaires were constructed – one for physicians and the other for nurses – based on the literature review and the theoretical model described above.

Validity and reliability

The questionnaires were tested for reliability and validity. Three physicians and three nurses with extensive experience in palliative medicine confirmed the direct variables, which consisted of intention, attitude and subjective norms. Test-retest reliability with a convenience sample of staff nurses ($n=5$) and physicians ($n=5$) at two different time points was 0.76 ($P<0.01$).

The questionnaire subjects included 59 items:

1. Background data: eight demographic items (age, sex, marital status, religion, level of faith, country of birth, year of immigration and ethnic origin); two variables related to education; three variables related to employment; three variables related to experience with terminal patients; and knowledge (seven items).
2. Model variables: behavioural beliefs (12 items; α[the significance level used to compute the confidence level]$=0.74$)*, behavioural attitudes (16 items; $\alpha=0.78$), subjective norms (4 items; $\alpha=0.73$), subjective attitudes (2 items; $\alpha=0.72$).

The two dependent variables were behaviour and behavioural intention. The answers were ranked on a Likert scale ranging from 1 (do not agree at all) to 5 (agree very much).

The study protocol was approved by the local ethics committee and national health authorities

'Respondents were asked whether they usually told 'bad news' to their terminal patients'

(The Helsinki Committee). After the necessary authorization had been received, a preliminary pilot study was held among 20 physicians and 20 nurses. Its purpose was to examine the clarity of all questionnaire components and the time needed to complete the questionnaire. The results of the pilot study showed a normal distribution of respondents' answers, proved the clarity of the questionnaire components, and showed that the time necessary to complete the questionnaire was 25 minutes.

The questionnaires were distributed personally by the researchers after providing an explanation of the purpose of the study and how to complete the questionnaire. Respondents were ensured anonymity and were promised that the data would be used for research purposes only. The data were gathered over approximately 4 months.

Data analysis

Data analysis was performed using the Statistical Package for Social Sciences (SPSS-PC). Descriptive statistics were used to depict the demographic characteristics of the sample and responses to the TRA and its subscales. The mean and standard deviation (SD) were calculated for each response. Pearson's correlation was used to determine correlations between TRA variables.

Results

The response to completion of the questionnaires was high (95%). Respondents comprised 100 physicians and 200 nurses, most of whom were working in general and geriatric hospitals in Israel. The mean age of participants was 40 years (range 24–67). Most of the physicians (57%) were male and most of the nurses (84%) were female. Most of the physicians and nurses were secular Jewish of Ashkenazi origin. Most of the nurses were registered (RN) with a graduate degree and advanced studies (52%).

Previous training and experience in caring for patients with terminal illness

Table 1 shows that most of the nurses worked in the geriatric field. The mean nurses' experience in the palliative field was 1.9 years (range 0–20). Less than 25% of the patients of most nurses surveyed (58%) suffered from incurable cancer or other incurable disease.

Most physicians were from the fields of gynaecology (27.4%) and internal medicine (24.2%). Less than 25% of the patients of most physicians surveyed (67%) suffered from incurable cancer, while 26–50% of the patients of most physicians suffered from a non-cancerous but incurable disease.

Table 1. Distribution of nurses and physicians by field of work

Field of work	Nurses		Physicians	
	%	*n*	%	*n*
Geriatrics	34.3	60	17.9	17
Surgery	10.9	19	7.4	7
Internal medicine	14.9	26	24.2	23
Oncology	0.6	1	14.7	14
Gynaecology	9.1	16	27.4	26
Others: premature infants, intensive care, newborns	30	53	4.2	4

Experience with disclosure of bad news

Fifty per cent of physicians estimated that they had disclosed to patients that they were terminally ill more than six times a year in the previous year. In contrast, 76% of nurses never took part in the process of disclosing information to patients with terminal illness. Those who took part in this process estimated that they had done so three times over the previous year. Respondents were asked whether they usually told 'bad news' to their terminal patients, whether they usually modified or gave only partial details, and whether they intend to routinely disclose bad news to terminal patients in the future.

Table 2 shows the percentage of caregivers disclosing bad news to patients with terminal disease: 63.4% of physicians vs only 38.7% of nurses always disclosed bad news or a negative prognosis to their patients, while more than 50% of physicians disclosed to their patients their impending death; 24.4% of physicians did not always disclose bad news. Nurses did not disclose bad news at all in 46.2% of cases, while 14% stated that they disclose the truth only in some cases.

Future behavioural intention

Future behavioural intention is presented in *Table 3*. Results show that 68.1% of physicians stated that future disclosure would depend on the circumstances of each case; only 24.2% claimed that they would disclose the truth regardless of the circumstances; and 76.1% of nurses claimed that in future they would disclose the truth depending on the case (i.e. more than they currently do).

As for personal preferences, physicians and nurses agreed that physicians, nurses and their family members believe that they should disclose the truth to their patients. However, the greatest agreement was reached around their own and their families' expectation of such behaviour. Physicians and nurses equally agree that they would like to be told, or would like their relatives to be told, the full truth about their own potential terminal illness.

Nurses and physicians were asked to whom they find it easier to disclose bad news. The distribution of answers is presented in *Table 4*. Findings indicate that physicians and nurses find it easier to disclose bad news to the elderly than to younger patients (ranked 3.4 out of 5). However, disclosing bad news was difficult regardless of the level of the patient's education or the presence of family members while disclosing bad news to patients; it was equally difficult whether information was given to the spouse or to offspring.

Training in disclosure of bad news

Respondents were asked whether they had already received training in the disclosure of bad news and whether they would be interested in receiving professional training. The results indicate that 78% of the nurses had not received such training but 70% would be interested in it; 55% of the physicians had not received such training and 28% would be interested in it.

Correlation between behavioural beliefs and subjective attitudes – and behavioural intentions and behaviour

Pearson correlations between the various variables were calculated and are presented in *Table 5*. A significant positive correlation was found between behavioural beliefs of physicians and nurses regarding the disclosure of bad news and actual disclosure (nurses $r=0.372$, $P<0.001$; physicians $r=0.389$, $P<0.01$); the stronger the behavioural beliefs of nurses and physicians, the greater the chance that they will disclose bad news to their patients.

A significant positive correlation was also found between the subjective attitudes of physicians and nurses to disclosure of bad news, and actual disclosure (nurses $r=0.408$, $P<0.001$; physicians $r=0.544$, $P<0.001$); the more positive their subjective attitudes to disclosure of bad news, the greater their chance of disclosing bad news to their patients. In addition, a correlation was found between the intention to disclose bad news and actual disclosure. This correlation was stronger among physicians (nurses $r=0.379$, $P<0.001$; physicians $r=0.802$, $P<0.001$).

No correlation was found between the knowledge of physicians and nurses regarding disclosure of bad news and actual and future disclosure. Differences between physicians and nurses were found regarding their intention to disclose bad news in the future. In nurses, a positive correlation was found between their behavioural beliefs and future intention to disclose bad news ($r=0.382$, $P<0.001$); the stronger the behavioural beliefs of nurses, the higher the chance that they would disclose bad news to patients in the future. Among physicians, however, a positive correlation was found between their subjective attitudes and future intention to disclose bad news ($r=0.544$; $P<0.001$); the more positive their subjective attitudes, the greater the chance that they would disclose bad news to patients in the future.

Table 2. Percentage of caregivers disclosing bad news to patients with terminal illness

	Physicians (%)	Nurses (%)
Yes	63.4	38.7
No	12.2	46.2
Only in some cases	24.4	14.0

Table 3. Behavioural intention – disclosing bad news in the future

	Physicians (%)	Nurses (%)
Yes, in all cases	24.2	16.3
Only in some cases	68.1	76.1
No	7.7	7.6

'The results indicate that 78% of the nurses had not received such training'

Discussion

Several studies indicate that patients are interested in learning the truth about their medical condition, be what it may, but many physicians and nurses do not disclose bad news. The reasons for this are varied. Different studies reveal a variety of behavioural attitudes among caregivers to the question of whether they should always tell their patients the truth. Those who believe that it is not always necessary to disclose bad news perceive their evasion of the truth as a way of protecting patients from distress (Lin et al, 2003). In addition, this approach seems to relieve some of the staff's burden while avoiding or decreasing the need to cope with both their own and their patients' distress, which tend to increase particularly in the absence of a clear diagnosis (Hirose, 1999). Some physicians claim that they do not disclose the whole truth to their patients 'since it is incomprehensible to them'

Table 4. Attitudes of physicians and nurses regarding specific subgroup in which disclosing bad news seems easier*

Subgroup	Physicians		Nurses	
	Mean	SD	Mean	SD
Educated patients	2.6947	1.30526	2.1263	1.24927
Offspring rather than spouses	2.5684	1.26030	2.1579	1.17573
The presence of family	2.7263	1.18898	2.7173	1.33127
Elderly rather than younger	3.4632	1.24465	3.1047	1.40283

* Values are rankings on a Likert scale of 1 (do not agree at all) to 5 (agree very much); SD = standard deviation

Table 5. Pearson correlations between the variables theory of reasoned action and intention and actual disclosure of bad news

	Current behaviour	Future intention
Behavioural beliefs:		
Physicians	0.389*	0.189
Nurses	0.372**	0.382**
Behavioural attitudes:		
Physicians	0.23	-0.36
Nurses	0.20	0.220**
Subjective norms:		
Physicians	0.439**	0.03
Nurses	0.14	0.273**
Subjective attitudes:		
Physicians	0.544**	0.45**
Nurses	0.408**	0.13
Knowledge:		
Physicians	0.27	-0.38
Nurses	-0.41	-0.38
Prior experience:		
Physician	0.37	0.802**
Nurse	0.24	0.379**

* $P<0.05$; ** $P<0.01$

because they cannot understand the truth as a result of memory problems or an inability to understand medical terminology (Hegerty et al, 2005).

Some physicians and nurses, particularly in non-Western countries, tend to submit to the family's will regarding disclosure of bad news to a sick family member (Lin et al, 2003). A large study conducted in several European countries found that 85% of oncologists do not disclose bad news to patients when relatives request that they refrain from doing so (Bruera et al, 2000). A study conducted in Greece found that nurses, like physicians, believe that most cancer patients are not interested in knowing the truth about their condition; in contrast, most nurses believe that it is necessary to disclose all the truth about a patient's condition to their family (Georgaki et al, 2002). Like physicians, nurses claimed that they had not received sufficient training in the disclosure of bad news, and this increases their predicament.

The main limitation of the present study is the fact that physicians and nurses were interviewed about their recall of experience, rather than as part of a prospective survey. Nevertheless, the study examined the effect of past clinical experience of medical and nursing staff in the disclosure of bad news on future intentions to disclose bad news to patients with terminal illness. Results indicate a correlation between prior experience and disclosure of bad news. Obviously, the differences found between physicians and nurses may stem from their different roles in treating patients with limited life expectancy: according to Israeli law, the physician is the one to disclose bad new to patients and families. The nurse can then continue and discuss the issue, but only after the main blow has been delivered by the physician.

Physicians who have more experience of disclosing bad news claimed that in the future they would not perform such disclosure in all cases, while nurses who had little clinical experience of disclosing bad news claimed that in the future they would always tell the whole truth. This study was not designed to determine causality; however, there are a number of possible reasons for these findings. It may be that, compared with nurses, physicians with experience of handling the subjective difficulties of individual cases base their attitude more on this experience and less on knowledge of the law. Another possible reason may be the concrete and complex human predicaments that physicians encounter (Grassi et al, 2000; Seo et al, 2000; Mystakidou et al, 2004). In this way, negative experiences might cause medical staff to avoid disclosing bad news to future patients. However, paternalistic decisions by physicians or families may lead to dissatisfaction with the medical system, causing increased stress, financial strain, and prolonged and painful deaths as a result of unwanted, invasive care (Smith and Swisher, 1998).

Our results indicate that positive behavioural beliefs and positive subjective attitudes towards the disclosure of bad news predict actual disclosure by physicians and nurses. Future intentions to disclose bad news may be predicted by the presence of positive behavioural beliefs and prior experience in nurses, and by positive subjective norms and prior experience in physicians, as this seems to reflect their differing role expectations. Physicians will disclose bad news when required to do so by their superiors in the department. Nurses do not perceive the disclosure of bad news as part of the role expected of them, but will do so based on their personal beliefs. The findings support the model of Ajzen and Fishbein (1980), which served as the foundation of the study.

Several recent studies found a correlation between attitudes and subjective norms affected by cultural perceptions and the decision whether to disclose bad news (Mok, 2000; Lin et al, 2003; Mystakidou et al, 2004). Our findings are in line with those of others in Western countries (Smith and Swisher, 1998; Wallberg et al, 2000; Hagertty et al, 2005). Research conducted in the French-speaking European countries of Belgium and Switzerland (Levarato et al, 2004) found that nurses and physicians disclosed cancer diagnoses to more than 60% of their patients; some

physicians approve of informing patients of their diagnosis and prognosis even when patients prefer not to be told (Wallberg et al, 2000).

Our findings are compatible with those studies. The reason for this may stem from the fact that most of the caregivers in the current study were of Ashkenazi origin, i.e. products of Western cultures (Elger and Harding, 2002). In contrast, in eastern societies such as China and Hong Kong, the family is more significant than the individual. Thus, in such societies it is customary to disclose bad news not to the patient but to family members, who then decide whether to disclose it to the patient as well (Mok and Martinson, 2000). In Taiwan and Japan, the situation is similar. In a study conducted in Japan among 147 Japanese nurses, respondents stated that they did not disclose the truth to patients with terminal cancer because this attitude would be contradictory to basic Japanese cultural perception of the individual as part of a group that can make decisions for the individual (Konishi and Davis, 1999). This cultural issue is worthy of continued scientific attention.

One may argue that the findings would be different in an Orthodox Jewish setting – both the bad news telling and the perceptions of caregivers. Unfortunately, we did not have Orthodox Jews among our physicians and nurses, but exploring the secular/religious interplay would certainly be an important issue for future research. Furthermore, comparative studies regarding differences in the cultural aspect of decisions reached by physicians and nurses in different societies should be performed. In the future, social scientists may help to ascribe differences between subjects to ethical, cultural or sociodemographic characteristics of the population. In addition, studies similar to ours should be performed in physicians and nurses working in the community setting.

Conclusion

Our conclusion is that caregivers find it difficult to disclose terminal status information to all types of patients, although most find it relatively easier in the case of elderly patients. TRA may help to predict disclosure of bad news by physicians and nurses. Behavioural beliefs, subjective attitudes and prior clinical experience with disclosure of bad news were the main factors influencing caregivers' disclosure. The main predictors among nurses were behavioural beliefs and prior experience, and among physicians – subjective norms and prior experience. IJPN

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