EXPERIENCES OF CLINICIANS IN BREAKING BAD NEWS: A QUALITATIVE STUDY AT AIC KIJABE HOSPITAL

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A Thesis Submitted to the Institute of Postgraduate Studies of Kabarak University in Partial Fulfilment of the Requirements of the Award of Masters of Medicine in Family Medicine Degree

KABARAK UNIVERSITY

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The thesis entitled “**Experiences of Clinicians in Breaking Bad News: A Qualitative Study at AIC Kijabe Hospital.”** and written by **Sheila Mercy Anjiwa Sisela** is presented to the Institute of Postgraduate Studies, Kabarak University. We have reviewed the research thesis and recommend it be accepted in partial fulfilment of the requirement for the award of the Master of Medicine, Family Medicine.

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Lastly, I acknowledge my family. You have been my strength, inspiration, and greatest cheerleader! May this work remind you of the great role you play in touching the lives of many by just being the best family to me.

DEDICATION

I dedicate this work to every healthcare worker who has been courageous enough to practise medicine not only with their minds and hands but their hearts as well.

ABSTRACT

Breaking bad news is a daunting task that clinicians encounter quite frequently in practice. It takes a wide range of clinical scenarios. The process of breaking bad news has the potential to enhance the therapeutic relationship with improved outcomes for both patient and provider. Conversely, it can have a deleterious effect on both parties medically, psychologically, socially, and even legally through litigation. Providers have different experiences when breaking such bad news. These experiences vary depending on a wide range of aspects that could be categorized into three: environmental, patient-related, and provider-related aspects. Some aspects are modifiable while others are not. This study sought to explore the experiences of clinicians in breaking bad news and how they can be supported. This qualitative study was conducted in AIC Kijabe Hospital, a Level V teaching, faith-based hospital. The study population was clinical and medical officers across four cadres. It was conducted using focus group discussions with the use of a semi-structured interview guide. Inductive coding was done, and the report was done in narrative form with the use of graphics where appropriate. It was found that **c**linicians often share their experiences with those they consider part of their support system. The experience of delivering bad news varies among clinicians, and many admit that they do not feel adequately prepared for this task. Different aspects affect clinicians in different ways. Emerging areas such as the impact of dual relationships, spirituality, and stacking in breaking bad news need further research. Strategies for maintaining emotional and psychological well-being exist at various levels, including individual, team, and institutional levels. Clinicians have adopted both healthy and unhealthy coping mechanisms. Institutional support includes policies, training, logistical support, and psychological assistance.

Keywords: *Breaking Bad News, Bad News, Clinicians' Experiences, Healthcare Workers' Experiences, Impact on Clinicians, Clinicians' Support.*

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LIST OF ABBREVIATIONS AND ACROYNMS

APA	American Psychological Association
AICKH	AIC Kijabe Hospital
BBN	Breaking Bad News
CME	Continuing Medical Education
DNI/DNR	Do Not Intubate/Do Not Resuscitate.
FGD	Focus group discussion
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IUFD	Intrauterine Foetal Demise
QR code	Quick Response Code

CONCEPTUAL OPERATIONAL DEFINITIONS OF TERMS

Bad News – any health-related information that is perceived to drastically change one's future in a negative way.

Clinician - A healthcare worker who practices medicine in direct patient contact. It includes clinical officers and medical doctors.

Experience – The lived as well as perceived encounters.

Resident – A medical doctor pursuing a post-graduate program.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter contains the background of the study, the problem statement, the study justification, and the purpose and objectives. It also includes the significance and projected limitations of the study.

1.2 Background

Bad news is widely defined as any information that drastically and negatively alters the patient's view of his or her future (Buckman, 1984). When ‘bad news' is mentioned, many often think of death, whether an occurrence of it or a terminal illness that could lead to it. There is an argument, however, that there is no uniform evaluation of bad news. It is bad depending on the extent to which it results in some deficit in the recipient that persists after the news is received and is thus determined by the recipient (Ptacek & Eberhardt, 1996; Tidy, 2021). Bad news ranges widely in nature and magnitude- from receiving a new or recurrent diagnosis to a change in prognosis or failed mode of treatment or need to stop futile therapies, to death (Francis & Robertson, 2023). The task is enormous.

Yet, this task of breaking bad news carries with it the potential to enhance or break therapeutic relationships (Monden et al., 2016). It should thus be handled in the best way possible to make the most of it. Experience is defined as “…direct observation of or participation in events as a basis of knowledge; the fact or state of having been affected by or gained knowledge through direct observation or participation; something personally encountered, undergone, or lived through; the act or process of directly perceiving events or reality.”(*Merriam-Webster Dictionary*, 2023). In the context of this paper, the lived experiences of the clinicians, how they have been affected, what they have learned, and how they perceive all these, shall be explored.

In most settings in Kenya, the primary clinical team, comprising medical and clinical practitioners, is responsible for breaking most bad news to patients and/or their families. Bad news in the clinical setting is often delivered by the clinical personnel attending to the patient. This may, however, vary in other settings (Fontes et al., 2017). This comes naturally as part of the consultation process. How it is done and the experience of the parties involved, however, differ. Many variables come into play.

Clinicians differ in their level of preparedness, confidence, and approach to breaking bad news (Ferraz Gonçalves et al., 2017). Thirty percent of healthcare workers would choose to defer the task to another team member because, for one reason or another, they find it difficult. (Adeleye & Fatiregun, 2013; Alshami et al., 2020). Training in breaking bad news using protocols has been employed to facilitate this difficult task. Such training has been shown to improve the providers' self-reported confidence levels and their evaluation scores by observers, but with variable evidence of their impact on clinical experience (Berger & Ribeiro Miller, 2022; Francis & Robertson, 2023). Ironically, some studies have also shown that the more experienced or senior team members, who are often better trained in breaking bad news, were found to be more likely to defer the task of breaking bad news to younger/junior colleagues (Adeleye & Fatiregun, 2013; Alshami et al., 2020). This goes to show that while training and experience are key enabling factors in breaking bad news, there is more.

Breaking bad news is a process that occurs in a complex environment influenced by environmental, patient-related, and provider-related aspects (Atienza-Carrasco et al., 2018; Warnock et al., 2017). An interplay of these aspects makes every experience of breaking bad news unique – and often unpredictable for the healthcare worker. The constant state of anxiety evoked by an ensuing or past experience of breaking bad news can be detrimental to one's well-being and ultimately affect their work and health. Needless to say, a poorly handled process of breaking news causes harm to patients and their families and leads to poorer outcomes and even litigation (Alshami et al., 2020; Monden et al., 2016). There have been strategies aimed at improving the experience of breaking and receiving bad news. There has, however, been a skew towards safeguarding the well-being of the recipients (Ptacek & McIntosh, 2009). The clinicians, who deliver bad news, are also affected to a significant extent by the process (Berger & Ribeiro Miller, 2022; Dzierżanowski & Kozlowski, 2019). They, too, have to find ways of coping. Some have healthy mechanisms while others have developed maladaptive ways of coping, such as harmful use of alcohol, substance abuse, dark humour, detachment, and shutting down, among others. Some have suffered from mental health disorders, and a few have chosen to walk away from active clinical practice altogether (Francis & Robertson, 2023; Messerotti et al., 2020).

Several aspects influence the experiences of healthcare providers in breaking bad news - some modifiable, some not. It is thus important to understand what matters, what can be done better, and what recommendations can be made for best practice and improvement of the process and experience of breaking bad news by the healthcare worker. The word experience, as used herein, refers to the lived encounters of clinicians in breaking bad news, their interpretation, response, and awareness of how it influences their interaction with other people and their surroundings.

1.3 Problem Statement

Breaking bad news is an occupational hazard (Francis & Robertson, 2023). Healthcare workers have acknowledged it as a daunting task that is sometimes so overwhelming that about a third of them choose to let someone else in their team handle it (Alshami et al., 2020). The clinician is engulfed in fear of how the session would unfold – afraid of expressing emotion, being blamed, being perceived as incompetent for not answering difficult questions, afraid of arousing negative emotions and responses from the recipients and not knowing exactly what to do, fear that trust in them may be lost etc (Alshami et al., 2020; Francis & Robertson, 2023; Messerotti et al., 2020). When the provider is constantly faced with this anxiety, their well-being is affected, and their quality of life is compromised. They suffer moral injury whenever they feel their care, which includes how they handle bad news, is sub-optimal. The effects of which go beyond the case-in-point, beyond the workplace – as they ruminate(Francis & Robertson, 2023). It affects their home life. It sets in motion a distress cycle that drives many to seek ways of adapting. Unfortunately, some resort to drug use/abuse, isolation, emotional distancing, and detachment – yet some choose to walk away from clinical practice altogether (Francis & Robertson, 2023; Messerotti et al., 2020; Monden et al., 2016).

A significant amount of effort has been invested in preparing for and conducting sessions on breaking bad news. Medical training programs have incorporated communication skills, protocols have been developed, in-service training has been held, and impact has been evaluated in some settings. There has been considerable impact on the providers' confidence level and recipients' satisfaction (Berger & Ribeiro Miller, 2022; Francis & Robertson, 2023). A lot, however, still needs to be done. Armed with communication skills and protocols, the doctor is expected to be a hero who will take on any challenge and triumph. This little-spoken expectation of being 'superhuman' has left many wounded soldiers in disguise, yet their hurt leaks in unexpected and sometimes grave ways (Francis & Robertson, 2023). The impact of bad news on the provider has largely been underexplored, yet it ranks as a leading cause of stress and burnout among clinicians (Berger & Ribeiro Miller, 2022; Messerotti et al., 2020). There is a need to address the deceptive culture of invincibility and develop one of vulnerability that will see clinicians better prepared and supported in this very crucial and recurrent role of being the bearers of bad news.

In Kenya, studies around breaking bad news have been focused on the competencies, barriers, and the impact of training and protocols (Chumba et al., 2019, 2022; Karishma et al., 2020). These studies have focused on residents only. One study focused specifically on breaking bad news concerning a cancer diagnosis, which does not address the varied nature of breaking bad news. (Chumba et al., 2019). Breaking bad news is conducted by clinicians across cadres and specialties.

1.4 Study Justification

There has been much effort in breaking bad news. However, this has been skewed towards how clinicians safeguard the well-being of the recipients. Many of the studies done on clinicians have focused on their performance in difficult conversations, which include bad news. Thus, it is a gap that has been largely overlooked.

The few studies in the literature have examined various specific aspects of breaking bad news among specific groups – cadres (especially among nurses) and among specific specialties like physicians, oncologists, and palliative care practitioners. The latter especially zooms in on cancer. This excluded many other scenarios that sometimes catch both parties by surprise due to the mismatch in judgement between the recipient and the conveyer of bad news.

There is a dearth of phenomenological studies in this area. Exploring clinicians' experiences will help give a voice to this overlooked aspect of breaking bad news and highlight areas for clinician-centered support.A qualitative exploration of the experiences of clinicians across the various cadres and specialties will go a long way in building understanding of this topic in Kenya.

1.5 Purpose of the Study

The purpose of this study was to explore the experiences of clinicians in breaking bad news. The exploration was aimed at understanding the distress cycle and the coping strategies among health care workers. This will hopefully help optimise professional resilience and create safer and more supportive working environments.

1.6 Research Objectives

1. To describe the readiness of clinicians to discuss their experiences of breaking bad news.
2. To explore the experiences of clinicians in breaking bad news.
3. To understand ways in which clinicians can be better supported in their role of breaking bad news.

1.7 Significance of the Study

This study gives voice to the often-overlooked impact of breaking bad news on clinicians by describing their experiences with breaking bad news and highlights the need for the prioritization of their well-being in this respect for the mutual benefit of themselves and their patients (Søvold et al., 2021). It also seeks to understand the kind of support that clinicians find helpful in dealing with breaking bad news, including but not limited to training needs as part of curricula for training programs and continuous professional development.

1.8 Limitations and Mitigation Measures of the Study

The nature of the study called for a level of vulnerability from the participants that the researcher may not guarantee. This call for vulnerability may also introduce a selection bias, as individuals who feel unprepared to discuss their experiences may decline participation at the recruitment stage or fail to attend the discussion. Time limitation was also a hurdle – the sensitivity of the discussions needed ice-breaking, in-depth self-disclosure, and deep inquiry, which may have jeopardised exhaustive exploration of some themes or sub-themes. This was mitigated by the use of code saturation, as opposed to meaning saturation. The study explored the general experience of clinicians and may not necessarily delve into the unique experiences of different specialties and sub-specialties.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter includes are view of the literature on the topic, the conceptual framework, and a summary.

2.2 Literature Review

2.2.1 Understanding Experience

Experience encompasses direct participation, perception, and knowledge. The American Psychological Association introduces an aspect of consciousness and defines experience as “the present contents of consciousness”. APA defines consciousness as “Experiential or subjective interpretations…in terms of mental imagery; intuition; subjective experience as related to sensations, perceptions, emotions, moods, and dreams; self-awareness; awareness of awareness itself and the unity between the self and others and the physical world;” It further states that “… the contents of consciousness can be assessed to some extent by their report ability but must also, given their phenomenological nature, rely on introspection.”(APA Dictionary of Psychology, 2023). This builds up the definition beyond the direct participation and how that affects someone, to the interpretations (both objective and subjective) and self-awareness that it elicits, and how all that unites with one’s interactions with others and their physical surroundings.

Experience is complex, not a mere reaction to stimulus. It is a consequence of the daily interaction/ dealing with one’s surroundings. These interactions can be planned or unplanned. The surrounding refers to both the physical and social environment, as well as the perception of the experiencing person in their present state of mind, encompassing their mood, attitudes, capabilities, goals, and expectations. Experience is a non-sequential interplay of tension between the immediate, the past, and the future. It is derived from the ordinary flow of things, as well as the extraordinary moments therein. Experience is complex and should be looked at as a sum of its elements (Jantzen, 2013).

2.2.2 Readiness to Discuss Experiences of Breaking Bad News

Readiness refers to the state or quality of being prepared or promptly willing to or having ease with doing something(*Merriam-Webster Dictionary*, 2023). Given that breaking bad news is daunting and uncomfortable for many, there are various coping mechanisms (Francis & Robertson, 2023; Ganca et al., 2016). Avoidance or disengagement is one of these mechanisms that may come in the way of sharing experiences. Disengagement is proposed to be an unintentional reflex to protect one from potential discomfort or loss of control (Solberg Kleiven et al., 2023). According to psychologists, people may struggle to open up for one reason or another. (Solberg Kleiven et al., 2023) conducted a study in Norway that established some reasons that contribute to people holding back.

One was fear of evoking psychological pain, which is often coupled with some level of shame and the feeling that sharing emotions would attract criticism, more shame, and increased loneliness. Secondly, there is insecurity about one’s right to share and whether their contribution is relevant or important. This was due to people downplaying the importance of their experiences, employing self-blame for any interpersonal problems they have encountered, or finding excuses for their feelings. For some, the mind may be willing to open up, but they experience some level of mind-body dissociation triggered by the sensitive nature of the issue at hand. Some lack words to express what they feel or felt, some have an intense internal conflict as to whether they should share the personal experience or not. Some hold back as they perceive it as disloyalty to discuss other parties if they are not present in the room.

All these internal psychic and interpersonal aspects affect one’s readiness to talk about their experiences in the setting of psychotherapy. Some choose not to talk about it at all (Farber, 2003). There is a dearth of literature about reticence in the setting of group discussions and specifically amongst clinicians. The above, however, can be extrapolated given the similarity in nature of conversation about experiences as well as human responses to what is perceived to be potentially unpleasant. It is, however, postulated that black individuals tend to be less disclosing when compared to white individuals, and it is unclear what role cultural variations play in opening up(Farber, 2003).

2.2.3 The Experience of Breaking Bad News

The experience of breaking bad news begins with receiving the bad news, then preparing to have a session with the recipient(s) to share the news, and ends with handling the post-session effects. This section shall review the literature in the various steps highlighted, beginning with an understanding of the concept of ‘bad news’ as this plays a key role in how the rest of the process unfolds.

Understanding of Bad News

Bad news has been defined as any information that drastically and negatively alters the patient's view of their future (Buckman, 1984). In 1993, Bor defined bad news in the context of HIV/AIDs in four domains – feeling of no hope, a threat to one’s mental and physical well-being, risk of upsetting a lifestyle, and posing a limitation to one’s choices in life (Bor et al., 1993). These definitions focus on the recipient’s view. That implies that the determination of whether the information is good or bad depends on the patient and not the provider (Bor et al., 1993; Ptacek & Eberhardt, 1996; Tidy, 2021). According to Vanderkief and Gregg, the magnitude and form of bad news vary depending on the patient’s perspective as well as their psychosocial status (Vandekieft, 2001). For instance, an announcement of a positive pregnancy test may be exceedingly good news to one patient yet devastating to another. The diagnosis of severe malaria may come as a relief to someone anxious about the possibility of a cancer diagnosis, for instance. Bad news as perceived by the provider may be received in unexpected ways by the patient and/or their family. The misalignment in value judgment may be misinterpreted by the doctor as denial, emotional blunting, or lack of insight, probably due to a mental disorder (Messerotti et al., 2020).

‘Breaking bad news’ has been faulted. First, it is paternalistic, focusing on the provider (breaking) rather than the patient (receiving). Secondly, the use of the word ‘news’ implies something fleeting – and thus undermines the lasting impact of the information shared. Berger (2022) has thus suggested a shift from ‘breaking bad news’ to ‘sharing serious information’. When healthcare workers were asked what they consider as bad news, about 60% said discussing poor prognosis and transition to palliative care(Anuk et al., 2022). The most difficult tasks in breaking the bad news included introducing palliation, disease recurrence or relapse, failed intervention, and handling the family of the patient. Most providers (72%) find the most difficult part of the task is finding the balance between being honest and giving hope. Generally, 59% acknowledge breaking bad news as the most difficult task they have to perform in their practice of medicine (Anuk et al., 2022; Messerotti et al., 2020).

Planning to Break Bad News:

To do a task well, one has to be adequately prepared for it. The more difficult a task is, the more preparation should go into it. Planning in the context of breaking bad news entails reviewing clinical records, identifying a quiet and private place, blocking adequate time, notifying colleagues to minimise interruptions, preparing and mentally rehearsing how you will conduct the session, and preparing oneself emotionally for the exercise (Vandekieft, 2001; Warnock et al., 2017). There is a lot that the clinician goes through before they break bad news. In one study, it was reported that 97% of the time, the clinician feels either sad, anxious, or distressed before they break the bad news. The level of anxiety and distress dropped significantly after the task was completed, while sadness increased after (Anuk et al., 2022). It is thus crucial to plan for a debrief after the session is done. If it is anticipated, one should ideally talk to the recipient to find out whether there are particular people that they would prefer to have with them and arrange for that too(Vandekieft, 2001).Being systematic in how one plans and conducts a session helps to build one's level of confidence, makes the experience better for both parties, and also protects against burnout(Messerotti et al., 2020). In studies done in Turkey and Italy, most clinicians, about 90% and 65% respectively, take time to plan the process of breaking bad news (Anuk et al., 2022; Messerotti et al., 2020).

Conducting the Session of Breaking Bad News

How a session of breaking bad news should be conducted has received much attention with the development of a myriad of protocols. Training and post-training evaluations have been done with impressive outcomes – particularly in the areas of improved communication skills, empathy, and confidence levels (Ferraz Gonçalves et al., 2017). Clinicians who have received some form of training on how to break bad news have reported it to be helpful. Choosing words carefully is an important aspect that influences how the session goes, and how the recipient, as well as the deliverer, copes after the session. Expressing empathy,such as allowing time to cry, handholding, consoling, or offering tissues, is one of the soft skills that helps facilitate emotionally intense moments. Silence and effective listening have also been highlighted as key instruments to use in the session (Anuk et al., 2022). Being able to discuss the way forward or next steps should be part of the session, but this calls for a proper judgement on a case-by-case basis. Some may need time to absorb, process, and consult significant others before considering the next steps, while others may rely on the next steps. It is therefore important for the clinician to determine this as the session unfolds to make the correct decision.

After the session of Breaking Bad News

Once the session of breaking bad news is over, one would assume that it is done! However, a study explored the feelings of clinicians before, during, and after breaking bad news; they found that relief was experienced only 3.5% of the time (Anuk et al., 2022). The majority suffered residual anxiety, distress, stress, pessimism, concern, and hopelessness (Anuk et al., 2022; Fontes et al., 2017; Francis & Robertson, 2023). Sadness, in particular, went up by over 20%. This is often overlooked or downplayed. The clinician is expected to move on to other demanding tasks – sometimes another similar session – with little or no time to deal with these residual feelings. The more self-aware clinician will find proper ways of dealing and coping with it whilst a majority will slowly slide into maladaptive practices. This is also a major contributor to burnout (Messerotti et al., 2020). This aspect of delivering bad news has often been overlooked or handled passively, leading toadverse outcomes.

Aspects that Influence the Experience of Breaking Bad News

Several aspects make breaking bad news either easier or more difficult. We shall look at these in three categories patient-related aspects, provider-related aspects, and environmental aspects.

Patient-Related Aspects

People are unique. Patients vary in more ways than they are similar. They may differ in age, diagnosis, prognosis, cognitive state, preferences, culture, social status, language barrier, and social support, to mention a few (Adeleye & Fatiregun, 2013; Anuk et al., 2022; Ganca et al., 2016; Harris et al., 2003; Kpanake et al., 2016).

The patient's family also comes up as a strong factor – not just in their presence or absence to offer support but in their preference for disclosure (Warnock et al., 2017). Some family members request clinicians to withhold information from a patient, creating a dilemma for the clinician (Anuk et al., 2022; Ganca et al., 2016; Kpanake et al., 2016). This is especially rampant in Africa, especially when the prognosis is poor. This situation worsens when there are factions within the family with differing views or if the patient explicitly confronts or asks for information. (Adeleye & Fatiregun, 2013; Kpanake, et al., 2016; Vandekieft, 2001).

The reaction of the patient and/or their family also influences how the breaking bad news experience unfolds for the clinician (Anuk et al., 2022). Some take it in stride, and one is left wondering whether they effectively communicated or not. Some individuals enter a fight mode, which threatens the provider's safety. Some express no emotion at all, while others are too broken to discuss further at the time. Some individuals are easily motivated to pursue healing, while others are not.

In some cases, the patient's involvement in the discussion is limited by factors such as age (being too young or too old) or their level of comprehension, which is influenced by cognitive capacity, psychological condition, language barrier, or level of education. This often complicates the scenario, and the clinician may feel limited in how to communicate and offer support (Anuk et al., 2022).

Patients hold different cultural, spiritual, and religious beliefs (Ganca et al., 2016; Kpanake et al., 2016; Monden et al., 2016). This also influences how they receive and perceive bad news. For instance, some consider terminal illness as a punishment from some deity, while others consider it an opportunity to ‘get their house in order.’ Some appreciate news of imminent death so that they can fulfil their cultural or religious obligations/requirements before, while others consider it taboo to mention death. The clinician needs to be well aware of the patient’s preference and consider ways of respecting them while still staying objective.

Provider-Related Aspects

When breaking bad news, the conveyor is right at the centre of it (Berger & Ribeiro Miller, 2022). They bring with them a complex internal milieu that they often hope will not interrupt the task ahead of them. But this is far from the truth. The clinician’s values, beliefs, philosophy of life, perception, and fear of death are pervasive. Other aspects, such as fatigue, past experiences, grief, feelings of failure, self-condemnation, and other fears, including evoking and dealing with an emotional response from the recipient of the news, also come into play (Alshami et al., 2020; Dzierżanowski & Kozlowski, 2019; Vandekieft, 2001).

The clinician also has cultural influences to deal with. This may be due to their upbringing (home culture) or the general culture in their country of origin – especially for those working cross-culturally or in a previous workplace culture. They have to adjust to suit the patient and the current workplace culture. The clinician should not only be culturally intelligent but also be a good student of their patient to know what their preference is, rather than assume a blanket cultural approach (Anuk et al., 2022). Personality differences may also affect how they break bad news. Planners tend to follow protocols more closely than their spontaneous counterparts. Those who consider breaking bad news to be a stressful task have more difficulty and are three times more likely to suffer burnout (Messerotti et al., 2020).

Those trained in communication skills and breaking bad news - and have developed a mastery of these skills have it easier (Alshami et al., 2020; Anuk et al., 2022; Dzierżanowski & Kozlowski, 2019; Monden et al., 2016; Vandekieft, 2001). Clinicians with more years of practice may have it easier compared to their less experienced colleagues, who tend to be more vulnerable due to less emotional preparedness (Dzierżanowski & Kozlowski, 2019; Francis & Robertson, 2023).

Dealing with bad news often causes one to confront one's philosophy of life, spirituality, and death. Those with a well-defined philosophy are said to have it easier (Anuk et al., 2022; Dzierżanowski & Kozlowski, 2019). Interestingly, the age of the clinician may affect their attitude towards death. Older practitioners tend to have a defensive reaction to death and may have it more difficult to hold such conversations (Anuk et al., 2022). Yet, many still shy away from discussions around death and dying – even when it is imminent.

When dealing with patients, clinicians may experience transference or counter-transference. Those with longer therapeutic relationships with their patients and their families tend to feel more affected by the bad news and find it harder to break the news (Francis & Robertson, 2023). Some consider this pre-existing relationship facilitative. Experiences with other patients greatly affect how one perceives and communicates a grave diagnosis, for instance. Some clinicians also suffer a psychological barrier fuelled by the notion of invincibility. They find it difficult to ask for help when facing difficulty with breaking bad news or dealing with the cumulative effects of the task. This affects how they handle sessions as they become suboptimal in their engagement (Dzierżanowski & Kozlowski, 2019; Francis & Robertson, 2023).

Environmental Aspects

The clinic or ward setting may not always offer the best environment for sensitive conversations, and this negatively impacts the experience for the provider (Anuk et al., 2022). Needs like privacy, comfort, and supplies are often unmet in most places. Breaking bad news is also a time-consuming activity that is often slotted in between other demanding tasks, leaving the sessions rushed and with no time allocated for the provider to process and debrief before embarking on the other pending chores (Anuk et al., 2022; Francis & Robertson, 2023).

Good teamwork and debriefing are highlighted as facilitative aspects in the task of breaking bad news (Francis & Robertson, 2023; Ganca et al., 2016). Sometimes, these are undermined by systemic pressure due to staff shortages or heavy workloads(Anuk et al., 2022; Francis & Robertson, 2023). Organisational culture varies from place to place, and this also affects the experiences of providers in breaking bad news (Francis & Robertson, 2023). Given the cultural diversity in Africa, the approach should also vary depending on the community one is practising. Some do not appreciate full or direct disclosure, and others consider death a taboo topic and would not want to hold such discussions (Adeleye & Fatiregun, 2013; Harris et al., 2003; Kpanake et al., 2016). Likewise, the place of spirituality cannot be overlooked, especially in Africa (Kpanake et al., 2016).

In many cultures, suffering and dying are seen as sacred. In the setting of faith-based organisations, particularly, suffering is often perceived through a spiritual lens (KEAGGY, 2010). When spirituality and religion are central, there are tendencies to either accept the sovereignty of Deity without question or deny and reject bad news altogether as being the working of opposing powers that should be subdued or to uphold unrealistic hope (Holt et al., 2014). This may significantly influence how bad news is perceived and communicated by the provider and how the recipient responds.

How Clinicians can be Supported in their Role of Breaking Bad News

Having good support helps make the experience of breaking bad news less difficult for the provider (Francis & Robertson, 2023; Walker & Efstathiou, 2020). This support comes in various forms, namely training and mentorship, administrative support, teamwork, and psychological support, among others.

Training

Medical school curricula, as well as in-service education programs, should equip healthcare providers to handle bad news. This will help them cope with their feelings, attitudes, and behaviours as well as become good communicators when dealing with bad news. (Anuk et al., 2022; Ganca et al., 2016). Ganca et al (2016) further suggest that all healthcare professionals receive training in palliative care to communicate with patients and their families effectively.Thus,training should go beyond skills for running a session to include the coping mechanisms, too.

Protocols

Having culturally specific protocols for breaking bad news helps guide through a difficult task (Alshami et al., 2020; Anuk et al., 2022; Vandekieft, 2001). This is especially helpful when you have providers working cross-culturally and those new to the practice/ workplace.

Psychological Support

Interdisciplinary teams that provide psychological support during and after delivering bad news. Some healthcare workers find the presence of colleagues in the session of breaking bad news helpful(Francis & Robertson, 2023). This, however, has to be done judiciously, as a large team may overwhelm patients and/or their families. Support may be offered by empowered teammates or the addition of palliative care practitioners or psychologists to the team during the time of need. According to Ganca et al. (2016), all public hospitals should have hospital-based palliative care teams, as these teams are better trained in handling difficult conversations. Efforts should be made to have support networks for healthcare providers. Debriefs are one way of achieving this.

Self-care

Clinicians who frequently break bad news should develop self-protection strategies as well as prioritise self-care (Francis & Robertson, 2023; Søvold et al., 2021; Walker & Efstathiou, 2020). This may entail taking adequate time to process and gain closure on the unfavourable outcomes. Reflection has been shown to mitigate emotional exhaustion, depersonalisation, and diminished personal accomplishment(Francis & Robertson, 2023).The perception of being human should be emphasised to discourage invincibility, which leaves many suffering in disguise (Francis & Robertson, 2023).

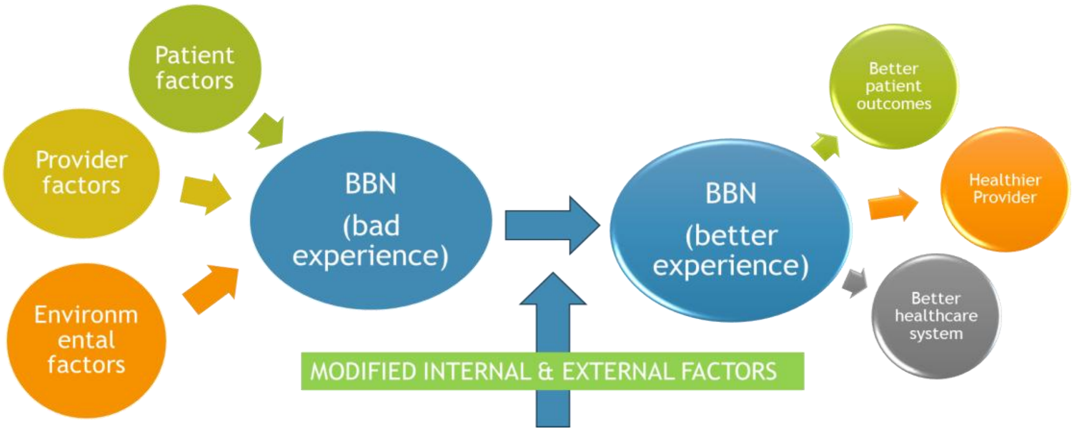
Administrative Support

The management of health institutions needs to have realistic expectations of the clinicians and facilitate them by providing the needed personnel, space, materials, time, and support for breaking bad news (Camilo et al., 2022; Karishma et al., 2020; Søvold et al., 2021). This may involve ensuring adequate staffing, facilitating teamwork, and fostering a healthy organisational culture (Francis & Robertson, 2023; Søvold et al., 2021). In areas where the language barrier is a significant limitation, it may be helpful to have translators within the institutions.

2.3 Conceptual Framework

Figure 1

Conceptual Framework



2.4 Summary

Clinicians have the difficult task of breaking bad news. The experiences they have depend on both intrinsic and extrinsic aspects. Gaining an understanding of these aspects and how they can be leveraged will go a long way in facilitating and supporting the clinician.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter includes the research design, location, study population, sample size, recruitment procedure, and the sampling process, as well as the inclusion and exclusion criteria. It also contains the data collection procedure and tools used, and how the data was managed, analysed, and presented. Ethical considerations are also included here.

3.2 Research Design

This was a qualitative, phenomenological study. It was conducted in AICKH among clinicians who get to break the bad news. It involved focus group discussions using a semi-structured interview guide. The focus group discussions were held in person, except for one that was done virtually due to challenges with scheduling an in-person meeting. The various focus groups consisted of participants from the same cadre. Focus group discussions were the most befitting method for this study as they allowed for data collection from the individuals, the group, as well as the interaction between the participants (Caillaud & Flick, 2017; Cyr, 2016). Hearing others share their experience reduced reticence and encouraged the sharing of varied as well as similar experiences and perspectives, which enriched the study.

3.3 Research Location

The study was conducted in AICKH, a level V b faith-based, referral health facility, located in Central Kenya. It has a rich and diverse workforce drawn from within and outside the country. It is also a leading training site for many medical and clinical practitioners from across Africa, as well as a good number of visiting students and fellows – mostly from the United States and the United Kingdom. It thus provided a great mix of cadres and cultures that enrich the study.

3.4 Study Population

It was conducted among registered medical and clinical practitioners as well as clinical officer interns working within AIC Kijabe Hospital at the time of the study. The participants were organized into cadres as follows: interns (clinical officer interns), registered clinical officers, medical officers and residents, and consultants.

3.5 Sample Size

Four focus group discussions were conducted, each consisting of five to eight participants. The achievement of code saturation guided completion of data collection - the point where new information did not result in changes in level two codes (Hennink et al., 2019). Given that the study population was a relatively homogenous group (all clinicians), 3-6 focus group discussions, with one group per cadre, have been shown to suffice (Guest et al., 2017).

3.6 Recruitment Procedure

The research principal investigator did the recruitment. Participation was voluntary, without coercion or inducement. The researchers approached the practitioners at strategic locations via phone calls and text messages. It included a brief on what the study is about and extended the invitation to participate. Those who accepted to participate were recruited into one of the four cadres. An interview date, time, and venue were set and communicated to the potential participants. Recruitment challenges included difficulty in harmonizing schedules to allow for an appropriate time for the participants. For one of the cadres, an evening virtual meeting is what worked.

3.7 Sampling Process

Purposive sampling was used to constitute the focus groups to have cadre-specific groups with heterogeneity in terms of specialty.

3.8 Inclusion and Exclusion Criteria

Any clinical officer or medical doctor who had broken bad news at any point in their training or practice was eligible to participate in the study. At recruitment, those who, for one reason or another, were not available during the study period were excluded. Those who would have expressed a lack of readiness to discuss their experiences would also have been excluded, but none did.

3.9 Data Collection Tools

Two tools were used. The first was a data collection sheet that captured the participants' characteristics that were of interest in this study. The form was provided via a QR code or link, and a few were available in hard copy upon arrival at the interview venue. The second was the semi-structured interview guide that was used to guide the focus group discussions. Both are attached-see Appendix 1.

3.10 Data Collection Procedures

Informed consent for participation and audio recording was obtained. Readiness to participate in the study was checked as part of the consent process and reiterated at the start of the focus group discussions. Access to the digital data sheet was granted for the participants to fill out and submit online. A few completed the forms in hard copy. These were later entered into the Google Forms by the principal investigator. The discussions were held guided by a semi-structured interview guide, and recordings were made using an audio recorder. Otter AI was used to help with real-time transcription. The focus group discussions lasted between fifty minutes and one and a half hours.

3.11 Data Management and Analysis

Data analysis was two-fold. The first was to establish initial descriptive characteristics of the participants, including readiness to participate. The second part began with the transcription of the focus group discussions. The interim analysis approach was employed. The 7-step data analysis steps as given by Marshall & Rossman (2006) were followed: data was organised, then internalised. This was followed by the generation of categories and codes, employing inductive coding. Themes were then generated, and the data interpreted. *Dedoose* was used in this phase of data analysis. An alternate understanding was sought from an independent reviewer. The report was then written in narrative form and with the use of graphics where appropriate.

3.12 Ethical Considerations

Formal approval was sought from the Kijabe Hospital Institutional Research and Ethics Committee (KH ISREC) and a research license was obtained from the National Commission for Science, Technology & Innovation (NACOSTI) before beginning the research. Both are attached – see Appendixes III and IV.

Recruitment was voluntary, and autonomy was respected. Informed consent was sought both for participation and audio recording. Confidentiality was upheld. Coding was used to disguise participants' identities. Recordings and documents containing participants' data were access-restricted. On the principle of beneficence, provision for psychological first aid was made for participants who may have uncovered sensitive areas, such as complicated grief/ self-condemnation, as a result of the interview. None of the participants required psychological first aid, but a number of them were advised and helped to seek professional psychological help.

CHAPTER FOUR

DATA ANALYSIS, RESULTS AND DISCUSSION

4.1 Introduction

This chapter contains the findings of the study.

4.2 General and Demographic Data

The study had 27 participants drawn from various cadres: nine interns, six registered clinical officers, five medical officers and residents, and seven consultants. During the time of study, the available interns were clinical officer interns. The other participants were drawn from various disciplines, namely: General Surgery, Internal Medicine, Obstetrics and Gynaecology, Family Medicine, Emergency and Critical care, Orthopaedics, as well as those in managerial positions. All 27 participated in the focus group discussions, but five did not complete the participant characteristics form. Of those who completed, there was an equal number of male and female participants. Most participants were between 20-30years of age (59%) and 30-40 years of age (36%). Only one participant was above 50 years of age. In terms of the years of practice, over 72% of the participants had five or fewer years of practice, with about 10% having more than 10 years of practice.

The majority of the participants (64%) were either working or had worked away from their country of origin in the course of their training and/or practice. In terms of preparation for breaking bad news, only 27% reported having received formal training in breaking bad news, alongside some training in palliative care. 64% had received training in counselling skills and 72% in communication skills.

Figure 2

Percentage of Participants Formally Trained in Breaking Bad News

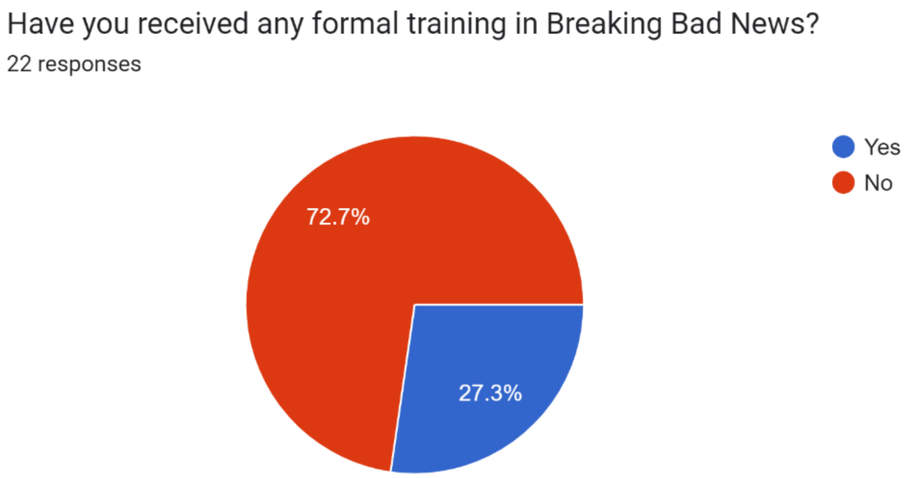
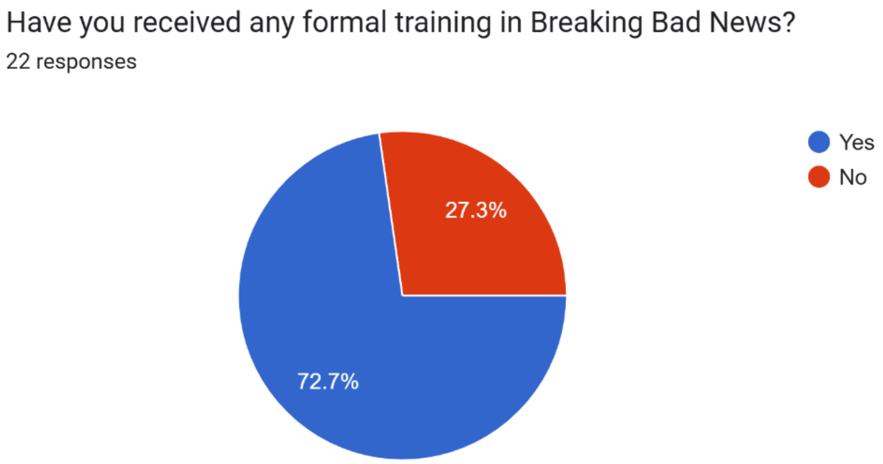


Figure 3

Percentage of Participants Formally Trained in Communication Skills



4.3 Readiness to Discuss Experiences of Breaking Bad News

Theme: Readiness to Discuss Experiences of Breaking Bad News

All participants expressed readiness to participate and freely shared their experiences during the focus group discussions. An opt-out form was provided for those who would have expressed a lack of readiness to share their experiences, but none did. Some participants reported that they readily share their experiences with those they deem part of their support system -mostly colleagues and family. The sharing was mainly to seek affirmation or appraisal.

> *"...we can turn to each other and say, 'hey, can you help me out or talk about what I could do better next time?'" P25*
>
> *"You go to the tea room and just try to share with people… just to hear what other people say" P18.*

The focus group discussions were appraised as helpful and therapeutic, which may explain the lack of explicit reticence in this study.

> *"...it was debriefing itself...it's encouraging...we can brainstorm together about how to make it better in the future." P23*
>
> *"...this discussion has also been helpful. At least getting to learn how your colleagues are managing all this, the tactics they use, and even getting to know how maybe we can improve" P7*
>
> *"It was a fruitful discussion… realize that I'm not the only one who struggles"P27.*
>
> *"I've just been able to sit and reflect on the entire process, something that sometimes is not possible in the activity of the days." P21*

However, it became challenging when the sharing involved a mistake that led to the bad news.

> *"I think it's hard for all of us to talk among physicians about when the bad news came from a mistake that we made or a mistake that was made."*P25

Another participant, however, had a varied opinion concerning sharing about a mistake that caused a complication; the participant readily shared her distress and ultimately got the affirmation she needed to carry on and even face the patient to share the news.

> *"...I caused a bladder injury, about 10cm, and I felt so bad. Yes, I was like, Doctor **, I am not doing a CS again. I went and told the consultants, I am done. If you want to just end my internship here, yeah, I'm done." P14*

Some expressed reticence to open up in a therapy session or hesitancy to seek help. This was largely driven by the reluctance to be vulnerable to another person. The easier option would be to keep it to oneself, albeit with difficulty. It was alluded that there may be a need to actually enforce such initiatives.

> *"...if you give us an option, none of us will go; we will die with our traumas."P11*
>
> *"...I thought even I needed a chaplain for myself. I never got the chaplain for myself, not that they're not available, by the way. I just didn't."P12*
>
> *"...we talkabout the need for therapies, but there are no institutions to push people actually to go there," P11*
>
> "*Yeah* (with others in unison) ...*You learn to deal with it*." P20

One of the reasons participants cited for opening up about their experiences with breaking bad news was that they would reach a point where they could no longer keep it in and thus needed to talk to someone about it.

> "*Sometimes, we tend to keep these things, but it reaches a point where you can't keep them." P11*

Some shared that it was to get feedback from their colleagues or support system on how they did.

> *"...just try to get to people even if you're not a medic... "if it were you, what could you have done?" just to hear that." P18*

However, there are some barriers to readily sharing one's experiences. From the foregoing , it is the sense of invincibility and the fear of what the sharing would evoke. Some said it feels odd. Some participants reported being negatively appraised by other team members when they expressed their emotions, which became a barrier to further discussion or seeking assistance.

> *"I was just there crying with the mom. And then the nurse was telling me, "Daktari analiana patient?" ('How is it that the doctor is crying with the patient?')" P6*

It is thus clear that barriers to sharing one's experiences can be internal or external, but there may be times when one makes a conscious decision to overcome them for the sake of one's well-being.

Clinicians' Experiences of Breaking Bad News

Themes of experiences of breaking bad news:

i. Scope and understanding of bad news

ii. Preparation for and conduct of breaking bad news

iii. Effects of breaking bad news on the clinicians

Theme 1: Scope And Understanding of Bad News

Table 1

Transition of Codes to Categories to theme - Scope and Understanding of Bad News

Codes	Categories	Theme
Death	Outcome	Scope and understanding of bad news
Surgical complication/error		
Any deviation from the expected/intended outcome		
Clinical deterioration		
Transition to palliative care	Prognosis	
Need for/ cancellation of a surgical procedure	Varied magnitude	
Diagnosis of a chronic illness		
Lost sample	Level of care	
Referral out		
Need for escalation of care		

Bad news varies significantly in various practices and settings. When participants were asked to share what they considered bad news, the scope was wide, highlighting the need to have an open mind and, as much as possible, empathize with the recipient of the news. Various codes emerged under this theme: -

a) Varied nature and magnitude

Participants acknowledged that bad news is variable. Some of the examples they shared varied from lost samples to the need for referral out, to the need for surgical procedures or repeat or cancellation of procedures, to the escalation of care or the ineligibility of it to death.

> *"…losing a pap smear, yes, it will be bad news." P11*

There was a general consensus, though, that while the provider is often the first one to attach value to such information, ultimately, it is the recipient who makes the final call.

> *"…whatever message we are sharing is not positive from their standpoint. It becomes bad news,"P16.*
>
> *"Sometimes it can be something not fatal, but life-altering, that will change life the way they have known it." P1*

b) Diagnosis and prognosis

Breaking news of a new diagnosis, especially a chronic illness, recurrent diagnosis, or a change in the goals of care – especially to palliation, was universally considered bad news.

> *"…telling someone they have a terminal illness or even just a chronic disease…" P4*
>
> *"Having to tell her that at the moment, we will have only to do palliative …" P14*

An interesting aspect of this, though, is that in some instances, the bad news may be received positively by the patient as they find closure.

> *“Mzee was actually happy with this information...’I have been suffering; I didn't know what was going on. But now I have a diagnosis…”P21*

Breaking news of a grave diagnosis and/or poor prognosis has the most impact on the participants.

> *“…these ones of bad prognosis ...stay longer with them, more interactions, and for some reason, their names, their faces, stick longer!”P11*

c) Outcomes of care

Bad news could also be a deviation from the expectations of either party.

> *“a deviation from an intended outcome with the effect that the patient has to suffer some detriments, either a complication or even eventual mortality, by and large, so basically deviation from what would be a good outcome.” P21*
>
> *“If you've done everything, and the patient is still deteriorating, and you have to explain to the patient.” P15*

A variation in outcome or process may be the need to escalate care or transfer care to another service or facility. The need for escalation of care speaks to a worsening clinical condition, and this is often viewed as bad news. An interesting twist arises when the need arises. However, the patient is either not a candidate according to hospital policy or the service is unavailable – either at that moment or not offered within the facility.

> *“…when you're escalating care, you find that some of them…think the prognosis might be bad.” P1*
>
> *“When you have to refer a patient out, ...if a complete facility, you can't help, they feel* there's *a probability that even where they are going, they still won’t get help.” P8*
>
> *“…the hardest bit was trying to tell them that, okay, we are not going to escalate care.” P14*

Death is often considered the worst possible outcome in many cases, and is often received with denial and resistance. In some instances, however, participants reported that they were surprised – albeit pleasantly- when they held family conferences for a dying patient and the families readily accepted and welcomed death as a form of rest for their loved ones.

> *"...you can be telling a family that they lost their loved one." P5*
>
> *"...So, the patient was very young to me. And the family was telling me, they have seen how the patient has really been suffering from that disease for a long time... And the best thing for her right now is just for her to rest - you, see?" P7*

Thus, the scope of bad news varies, and it is important to allow the recipient to make the judgement call while empathising with them.

Theme 2: Preparation and conduct of breaking bad news

Training, orientation, and mentorship. *Pre-service training was generally deficient in preparing clinicians to break bad news. Only one clinical officer mentioned that the curriculum they went through touched on it briefly; the rest did not have any training on breaking bad news taught in school. Among medical doctors, there were varied responses, with some saying they were trained theoretically. None reported a practical illustration or practice of this skill in training.*

> *"It is not taught in school," P5*
>
> *"Briefly...but it's complex and not standardized." P15*
>
> "*Our undergraduate training really has nothing to do with, or rather, even if it is there, it's not one of those hard-examined topics. So, people just cruise through…." P27*
>
> *"There's no practicals... and they give you mnemonics and you write an essay which you have crammed...Now I don't even remember the mnemonics (laughter and nodding in agreement)." P12*

Some participants reported that their first experience with breaking bad news was particularly challenging due to inadequate preparation during pre-service training.

> *"The first time I did this, I was crushed. And it took me a very long time. Because it was, I think it was during an internship. And it was very difficult… (had to) control myself not to break down before the patient." P4*
>
> *"I was with a chaplain. And I asked him, 'So, how do you assess how I went about the situation?' And he said that for the first time, it was not bad. But from my own point of view, I was really shaking, I was not really ready to deliver this information."P7*

For the participants, mentorship and apprenticeship were the main methods of learning how to break bad news.

> *"Preparation sometimes is, when you see your seniors (group agrees) how they handle it, you learn a thing or two." P12*
>
> *"I had someone senior to me, who sort of took over because he saw I was shaking…" P4*

The need for training in breaking bad news when one is entering into service, as well as periodic in-service trainings, were highlighted as essential to fill the gap in pre-service training.

> *"There is more that is needed in preparing the younger doctors who are coming on how to do this." P23*
>
> *"…there may be value in having some course of sorts, the benefits, integrating breaking bad news, as you know, a lecture or two in the course of our didactics, even with the residents." P10*
>
> *"Also, CMEs… teach other people around it. So that you improve their knowledge base…" P16*
>
> *"School, yes, but on the ground too...periodically. Revisit." P12*

One participant shared how taking a separate course on grief counselling immensely helped her with breaking bad news. This sparked a lot of interest from the other participants, highlighting a need to take/offer such courses.

> *"(I) did some grief counselling classes sometime back. And I think one thing I have to learn is that there's a way to do it, and beyond just breaking the bad news, even how to support them. And I think it's important." P11*

> **Case preparation.** *Case-by-case preparation varied greatly between different participants, disciplines, and settings. In acute care settings like the emergency department, outpatient clinics, and most clinics, patient interactions are brief, sometimes fast-paced, and not often easy to predict; thus, the level of preparedness was often not sufficient. The inpatient setting had a bit more time to prepare and break the bad news.*

> *"For admitted patients, we also have a bit more time…to be able to call the next of kin…" P23*

> *"…I had the liberty of time to go through diagnostics and simplify the diagnosis of what I was about to give her in lay terms."P24*

To mitigate the challenges in the clinic, one participant shared how they keep a log of the patients they are expecting to see in the scheduled clinic and are able to anticipate discussions that shall ensue, and that helps them prepare for most of the conversations. Some participants from surgical disciplines also shared how they anticipate discussions around life-altering procedures or biopsy results beforehand and prepare accordingly, which helps them when breaking bad news to patients.

> "*And it's so the way I prepared myself is to try and think of how, for example, after the amputation, how life would end up looking like after that…we have an orthopaedic workshop nearby. I need to get details about that. So that even as I disclose information to the patient, I try to paint a picture of how life can still continue. I have something tangible I can explain." P27*

For most inpatient teams, it was easier when conversations began early in the encounter with the patient and family, and appraisals were done along the way. This highlighted the importance of harmonized discussions from outpatient or emergency departments to inpatient teams.

> *"…for like prognosis purposes, I try to walk with the people, try to develop facts early enough…So that it will take small portions every time and not that I am coming to tell you at once." P20*

Another important part of preparation was seeking or refreshing one's knowledge about the topic of bad news. This was particularly important to help navigate patients' and their families' questions and concerns.

> *"…I had more knowledge on the condition of how I can illustrate it to the patient…" P18*

Enlisting help from other disciplines was also cited as an important or helpful part of preparing to break bad news. Multi-disciplinary teams, however, were not easy to put together in the outpatient department.

> *"And we try to approach it as much as possible as a multidisciplinary team... So, we have palliative team on board...oncology… chaplaincy…clinical psychology, we try to get as many teams that will support the patient beyond that family conference." P23*
>
> *"I wish you could get even in outpatient the same kind of team put up together like in inpatient the way…I guess it's possible, but I don't think we have done that. I think having a bigger team might make it a bit easier for you to share the load." P25*
>
> "*…And oftentimes in the clinic, it's difficult to have chaplaincy, although, when I'm on the inpatient side, the last time I remember I was able to get chaplaincy on board…" P21*

Some participants however, felt that nothing really prepares one to break bad news and that each experience was unique and impacted them differently.

Dealing with patients and/or their families. *Responding to questions, reactions, and expectations from the patient is a significant part of breaking bad news. Many clinicians approach this aspect with anxiety and uncertainty.*

> *"There's that session where they now ask you questions, that is the difficult session," P16*
>
> *"She kept saying, I believe in God, and you guys are bearers of bad news, and I refuse to accept it." P12*
>
> *"I wasn't joking when I said I like to position myself in a position I can easily leave the room...a marker of how uncomfortable I am with these conversations. Like, my main instinct is to get out. And I really have to override that instinct and stay ... what makes it hard is when the family reacts really poorly. Like when they scream and cry and fall on the ground." P25*

Sometimes, part of breaking the bad news involves helping with disclosure to the family of the patient or being asked not to disclose.

> *"…she had also withheld…the relatives think the* patient has been doing *well…asking consent again from the patient, is it okay we allow the relatives to know where we are…"* P11
>
> *"…she kept getting worse, and every day she's swearing us to secrecy…" P12*
>
> *"…I was called to say that he has passed. But I should not break the news now." P13*

Handling families with conflicting interests is also a common occurrence in breaking bad news. Sometimes, the patient's family has interests that do not necessarily align with the patient's. One common one is disclosing a grave diagnosis to a patient.

> *"Mzee was actually happy with this information. He said, "I have been suffering; I didn't know what was going on." But now I have a diagnosis.*

> *The wife, on the other hand, wasn't happy that I had told Mzee he had cancer." P21*

> *Aspects that make breaking bad news harder or easier. When asked to reflect on what made their experiences of breaking bad news easier or harder, many aspects were discussed. They varied from the patient, their family, the clinician, and the environment where the bad news was being broken.*

A. Patient-Related Aspects

Patient demographics were a key factor, particularly age. Many participants found it more challenging when the patient was a child or young adult with a young family, or at the beginning of their most productive life. The difficulty arose both internally (how the clinician perceived it) and externally (how the recipient - mostly the family - took it).

> *"…why this child? I think I get more affected with the kids because I feel like they still have a long way to go, rather than the adults…" P18*

> *"…when you look at a young person leaving a small child behind, it's actually very discouraging to, very heartbreaking…to even have to break that news." P23*

> *"For the extreme of ages, you find that some people may accept the bad news…". P20*

> *"…they are at their mid age…they have started their career…it was to help the whole family…it's not a really good discussion to have."P20*

It was reported to be much easier for patients with good family and social support than for those with none or a poor support system. Poor social support due to a patient's lack of disclosure also further complicates the task for clinicians.

> *"…they usually need support from family… the children helped her to understand…" P10*

> *"It's easier when a patient has good social and family support."* P12

> *"Another thing that was hard was I didn't even break the news to the relatives...she didn't want to bear that burden on the relatives…" P11*

Participants also highlighted the expectations and level of understanding of the patients and/or families. When the outcome was expected, it was easier to break bad news. Good patient education, constant appraisals, acceptance, and good therapeutic relationships often facilitated this.

> *"But I think what makes it easier is if you start with these people early on, then you prepare them for the worst and hope for the best. Then that makes it easy." P14*
>
> *"What makes it a bit easier is if the family understands that the prognosis is bad," P19*
>
> *"Then I think what makes it easier for these chronic illnesses is that at the point of entry, this conversation should start, so that when I meet this patient, I should be continuing with the discussion, not initiating it." P20*

Another important factor was the patient's belief system. Both cultural and religious beliefs played a role in the experience of breaking bad news.

> *"So, I knew eventually he was going to pass, but I've not told anybody… I knew first, the culture - how we break bad news."* P13
>
> *"You're talking to an African family, you can't easily just tell them your patient is going to die, yeah, you have to beat around the bush…" P14*
>
> "*…she kept saying, I believe in God, and you guys are bearers of bad news, and I refuse to accept it."* P11
>
> *"We were being quoted for the name of Jesus. It was quite dramatic. But, you know, it's a hard thing, because even I have faith in God."* P14

The patient's and/or family's reaction also influenced the clinician's experience.

"I think, for me, what makes it hard is when the family reacts really poorly. Like when they scream and cry and fall on the ground. And that makes it much more just heartbreaking for me." P25

b. Provider-Related Aspects

From their perspective, some factors about the clinicians also played a role in their experiences.

The first is the nature and duration of therapeutic relationship. Some find it easier when they have had a considerable amount of time taking care of the patient and their family, while others said it was harder for them as they easily got attached to the patient and family.

> *"…harder when the family knows you."* P10
>
> *"It makes it easy when it's a patient I have walked the journey with, or at least even if not personally, at least the patient was informed step by step about how things are going. If things are getting worse, the patient is updated. You can refer back to previous conversations about the progression of the disease." P27*
>
> *"…it varies with the care that you give to them…if you have spent a short time with the patient, maybe it will be easier to get over with."* P16

Level of knowledge on the topic of discussion also influences one's confidence level and hence experience, especially when questions start to arise during the session of breaking bad news.

> *"Like, at that time, it wasn't like that draining to me because…I had more knowledge on the condition of how I can illustrate it to the patient." P18*
>
> *"He knew everything, he had come with the notes…what you will tell this patient because already they have the knowledge…" P19*

> *"...you have this interesting case; you just try to teach other people around it. So that you improve their knowledge base..." P16*

Teamwork was also mentioned as a key facilitator – especially the presence of a senior colleague (or just one other person), or other disciplines like palliative, psychology, and chaplaincy.

> *"The other thing that makes it easy is I feel like I have a colleague or a senior who is supporting me."* P14
>
> "*What makes it hard is that when I was a junior, I always had seniors there. Now I'm the one who's called, you know, you feel like you can't put so much responsibility on your shoulders. So that makes it hard."* P27
>
> "*So, it was really challenging, because that night, it was my first time, and I was confused and scared. But I was lucky because we had someone senior to me..."* P9
>
> *"It's easy because you're not alone. Alone. So, there's always someone available from the first on-call to the consultant. So that makes it easy because the other people can help you." P1*

Sometimes, bad news arises from a lack of cooperation on the part of the patient. In such times, clinicians are a bit conflicted – balancing the disappointment they harbour whilst showing compassion at the same time.

> *"...didn't adhere to the plan. So, then the next time she came, we couldn't find the foetal heart...So, you feel conflicted. You can see how affected she is, so you can't be too hard on her. You try to accommodate. So that was a very challenging situation."* P12
>
> *"He understood what was required, but I guess he was adamant, because he had that surgery on this other foot without it getting amputated. But now you tell him this other one, there is no way we can just go and debride...so he refused, and we had to discharge him against medical advice. He went, came back very sick, and died.*" P10

Another significant area is faith-conflict. When the patient rejects the bad news and/or plan of care, citing religious reasons. This was especially pronounced amongst participants who said they too had faith in God and could either not reconcile their theology and suffering, or could tell the patient was in outright denial, masking it as faith.

> *"But what makes it a bit difficult is where, of course, there's a faith aspect, where they still believe in something that can be done, yet there's nothing that can be done."* P14
>
> *"We are being quoted for the name of Jesus. It was quite dramatic. But, you know, it's so it's, it's a hard thing, because even I have faith in God." P11*
>
> *"She started calling on the name of God again, you know. So that for me was very hard"* P12.
>
> *"Sometimes I wonder about faith, faith, and bad prognosis, how to discuss because I'm a firm believer in God. I speak in tongues, but sometimes there are some hardfacts,"* P13.

The African culture cannot be ignored. When it comes to dealing with bad news, culture was highlighted as a hindrance. Culturally, death is taboo, and so one cannot openly tell a patient that they are going to die. Secondly, some clinicians felt that it would not be culturally appropriate to grieve with the patients and/or their families.

> *"I knew first, the culture - how we break bad news…I had to wait"* P13
>
> *"…in an African setting, or you're talking to an African family, you can't easily just tell them your patient is going to die…you have to beat around the bush…manage the expectations and see if the point is taken…"* P14
>
> *"…in the African setting, you are not allowed to grieve-ish, in a way."* P14

Another interesting theme was the impact of stacking bad news. Every experience of breaking bad news affects the clinician. The effects accumulate over time, depending on how often one has to break bad news. Sometimes, a single patient encounter can reveal multiple layers of bad news.

> *"…we had three occasions of having to break bad news…in the end, we were breaking the utmost bad news…we had to break bad news to this patient multiple times in the same (encounter)" P12.*
>
> *"…there was a weekend, I was on call, and we almost amputated four or five patients, to the point where you are like…we really need to do more vascular surgery."* P10
>
> *"During the strike days, I broke bad news so many times to mothers whose babies died like IUFDs. At some point, I just sat in the tea room, and I was like, I think I just need a chaplain for myself." P12*
>
> *"Like ICU, let's say you've had like, three deaths in a day*." P10

Struggles with dual relationships proved to be a challenging aspect to deal with. This was mostly in the setting of family members expecting the clinician to be of both professional and social support. It was emotionally daunting.

> *"I had to help somebody break bad news to somebody who was close to me…I had accompanied *** as the next of kin, so I was translating this information (of cancer diagnosis) to him.*" P13
>
> "*You know, when you're a medic, your family knows you are a medic, and then if someone in the family is very sick, they look to you. And this is where the blessing of knowledge becomes such a burden."* P12
>
> *"...I was a bearer of bad news as a sibling, who is a medic, and it was terrible…"* P12

Participants reported that they faced counter-transference and transference, which made the experience of breaking bad news more difficult. Some sought professional help from psychologists to overcome this when it constantly came in the way of their work.

> *"Being a mother...it just broke me all the more. I imagined my two babies…I couldn't even imagine how the husband was feeling, the mother…till today, I*

> *haven't reconciled…if this could happen to a mum like this, what makes me think it cannot happen to me?"* P11

> "*My *** had cholangiocarcinoma, every patient with that, I knew the prognosis was bad, until I was not seeing them…I had to tell the senior resident that I cannot see any patient with cholangiocarcinoma" P13*

> *"So, it makes it very difficult when the child is my child, one of my kids' age, it gets very, very difficult… I think I identify with that family more."* P26

A. Environmental Aspects

A conducive work environment where one can get support helps ease the difficult task of breaking bad news. Some clinicians reported that they found their work environment conducive.

> "*And then of course, I think we have a supportive environment around."* P27

> "*Our culture is so supportive. I mean, here we are having this conversation, which would not take place at a hospital with a bad culture. But I think it's important to recognize that our culture is very supportive. It's very understanding*." P25

> "*That is such a privilege, like having such a platform. That is a conducive environment, allowing you to express yourself and grow*." P19

Conversely, high expectations coupled with a high workload and pressure to perform can make it difficult for clinicians to break bad news and handle the aftermath properly.

> "*We don't. It almost felt like a luxury to sit and process, you know."* P11

> *"You, the person who has broken bad news, you are supposed to go back to work, as you definitely have other patients you are supposed to take care of."* P5

Some expressed that the pressure is sometimes from within – seeing the pressing needs around, they must quickly carry on with the pressing tasks at hand. At times, the pressure comes from the team.

> "*So, you just pack it somewhere, gather yourself, and go on with the day, because this one is alive and their baby is alive. So, in the back of my mind, I'm thinking if I take a lot of time breathing, I might just have to break the news to this one*" P12.

> *"You are in casualty; you have like 10 patients and you are alone. Next, you will discuss the DNI/DNR status of a patient. Two others have just walked in, and you need to go see them. And then you have to be very fast. So even your mind is racing as you're delivering this news."* P20

> *"…you are breaking news in the outpatient…you have found this patient is very sick, and you are trying to explain what is going on. Then you are told, "The queue is long' and you are in the process…"* P15

Some participants shared instances of conflict between their beliefs on what could or should be done and the patient's desires, sometimes supported by hospital policy.

> *"So even at the moment, she wants a full code, and of course, if it's in disagreement with our policy currently in terms of her clinical diagnosis, but we left them at that, because that's her wish." P12*

> *"…what makes it a bit difficult is where you're in scenarios where you own value, where your own principles are questioned" P14.*

Many considerations influence a clinician's experience. Some of these aspects can be modified to make the task of breaking bad news more bearable for the clinicians.

Theme 3:The Effect on the Clinicians and Their Coping Strategies

Table 2

Transition of Codes to Theme - Effects on Clinicians and Coping Strategies

Codes	Categories	Themes
• *Fear, sadness, hopelessness*	Emotional reaction	Effects of breaking bad news on the clinicians and their coping strategies
• *Anxiety, incompetence, and traumatized.*	Psychological distress	
• *Faith and suffering* • *Faith vs Denial*	Spiritual conflict	
• *Autonomy vs beneficence* • *Values vs Policy*	Ethical dilemma	
• *Lean on faith* • *Seeking support from colleagues* • *Support from family* • *Sublimation* • *Intellectualisation* • *Self-reflection* • *Avoidance*	Coping strategies	
• *Reduced focus* • *Reduced productivity* • *Rumination* • *Counter-transference*	Impact on work and life	

Emotional and psychological reaction. *Breaking bad news had an emotional and psychological effect on the clinicians. Some reported they often felt ill-prepared, anxious, and overwhelmed by this task. Sadness and helplessness also came up as a common reaction.*

"...it's a bit overwhelming." P3

> *"Find that it's traumatic, not just for you, as a clinician, not just for the patient" P1,*
>
> *"…So, I left, I left Kijabe, and I didn't come back on Monday. So many people are calling, and I was not picking up." P11*
>
> *"Think every experience is different. And as much as we say we have experts in breaking bad news, some do hit you harder than others…sometimes, you just feel discouraged… very heartbreaking… to even have to break that news." P23*
>
> *"Sometimes I struggled with feelings of incompetence." P10*

Fear was a prominent emotion among the participants. Fear of conducting the session, fear of reaction from the recipient(s), fear of taking away hope, fear of inadequately handling the questions and concerns of the patient and their family, or for some, fear of being blamed or appearing incompetent.

> *"So, it's scary...you don't know how they're going to take it."* P4
>
> *"And then there's that session where they now ask you questions, that is the difficult session…"* P16
>
> *"So, when the family comes…you can't answer their questions, it feels awkward for everyone. But that's usually what happens."* P20

Spiritual reaction. *Breaking bad news puts the clinician on the spot, both professionally and spiritually. Participants reported that it raised questions about their own spirituality.*

> *"We are being quoted for the name of Jesus…it's a hard thing, because even I have faith in God…God could change it tonight, I don't know, but as of now, this is what it is..." P12*
>
> *"Sometimes I wonder about faith - faith and bad prognosis. How to discuss because I'm a firm believer in God."P11*
>
> *"… this aspect of faith, where they still believe in God. But you, as a medic, you know, yeah, like, you know, faith cannot help in this case, because it's very extensive" P14.*

> *"So sometimes, when there are those situations, when someone says, I have a covenant with God, for me personally, I'm so torn, because I know that when we've hit the wall, still, God can be something. That's why I ride on their faith." P11*

Some participants said they enjoin their faith on the patient, others resort to prayer, and others engage the patient on matters of faith to cope with this conflict.

> *"I think for us, routinely, we just pray. We pray for the patient and the family. We let them know the final outcome is in God's hands" P23*
>
> *"I agree with *** about praying, talking about eternal matters." P25*
>
> *"So, I think we also have to look at our spiritual part, where you have a role to play as a Christian. Both to yourself and the patient"P17*

Ethical dilemma. *Some participants shared about the times when they are caught between respecting patients' autonomy/confidentiality or following hospital policy and doing the needful.*

> *"She wants a full code, and of course, if it's in disagreement with our policy."P11*
>
> *"…scenarios where your own principles are questioned…there's a hospital policy that says do not intubate, do not resuscitate. But in other places, these patients are intubated and they do survive, even after being intubated…" P14*
>
> *"We are just doing palliative care and…don't talk about tomorrow...patient doesn't want us to talk about any coding status." P11*
>
> *"We have to go back and forth…asking consent again from the patient…she has children…we need to discuss… prepare for the death and preparing what happens to the children, and all those kinds of discussions…'' P11*

Coping strategies. *The participants reported having various ways of coping with the effects of breaking bad news.*

Faith

A number of participants said they lean on their faith to help them cope, sometimes despite their own faith conflict. One participant shared about how, at some point, they felt that praying did not work for them.

> *"As a Christian, with God's help, I will be able to control everything that is happening in my life." P17*
>
> *"We tried praying, and nothing worked for me on that day; I really felt disappointed." P6*
>
> "*That's why I ride on their faith,"P12.*
>
> *"The thing that at least I was able to do always is to pray…with time, you learn to say you have done your best, and it's really in God's hands." P21*

Seek support from colleagues

Participants reported seeking support from colleagues.

> *"You go to the tea room and just try to share with people…" P18.*
> *"We try to debrief after that. That's why I'm talking about tea, so you have tea and try to talk about it." P20*

Seek support from family

Family was another source of support for the participants, albeit remotely via phone calls and, for some, in person.

> *"You go home, you feel sad, you cry, you call your parents." P1*
>
> *"My husband is my therapist… (two others chime in agreement)" P12.*

Intellectualization

Some participants' primary way of coping with the undesirable effects of breaking bad news was to immerse themselves in reading, learning, and improving.

> *"Every time I have to break bad news. Yeah, I read a lot afterwards, because I'm like, what did I miss? Let me make sure I never miss that the next time" P16.*

> *"I think I always try to come out of these better somehow, like instead of avoiding thinking about it, and I try to think about what mistakes were made, what system errors might have been present... There is a lesson that I need to learn, that we need to learn…." P25*

Self-reflection

> *"I think it's usually not easy. Sometimes you sit there and try to reflect on things that you could have done." P22*
>
> *"...I try to think about what mistakes were made, what system errors might have been present...there's a lesson that I need to learn, that we need to learn. You know, I think to myself, why am I so uncomfortable, and what should I change? My impulse to change is even stronger, the more uncomfortable I am to go find what happened or what mistakes I made or what system errors happened that we can correct." P25*

Sublimation

For some participants, redirecting their energies to other useful activities helps them cope.

> *"You'll just go to your house, read a book, push it at the very back of your mind and move on. I know it's not the best coping mechanism, but it helps sustain you. You can face the next day for sure." P14*
>
> *"There are instances that I have had to just find ways of unwinding that would mean, you know, going to run as much as I can over the hill. Yeah, just to just let it let it out." P21*

Impact on work and life

> *Breaking bad news was reported to affect the life and work of clinicians in various ways and to varying extents.*

a) Reduced focus and productivity

Some participants reported feeling 'stuck' when breaking bad news, as they are not fully present with the patients who follow.

> *"I have been in situations where I am seeing a patient and I am staring at the desktop. The patient is talking, and I am like, "pardon," my mind is like, "what did I tell them? What will happen?" P19*
>
> *"Your productivity goes so slow, you deliver, but you feel a bit down, you are absent-minded, you are not focused." P15*
>
> *"You can't just finish breaking the news, then immediately you are being given a patient…it can have catastrophic consequences."P16*

b) Rumination

Long after breaking bad news, many participants reported they still find their minds dwelling on the experience, sometimes to their detriment.

> *"I feel sad… after I have told them and they have gone home, you are stuck. So, I carry that with me," P7.*
>
> *"I still feel, even till today, I haven't reconciled. I am still broken…"P11*
>
> *"You keep contemplating, when that patient leaves, remember again." P19*

c) Transference and counter-transference

> *"…it makes it very difficult when the child is one of my kids…I identify with that family more."* P26
> *"…if this could happen to a mum like this, what makes me think it cannot happen to me?"* P11

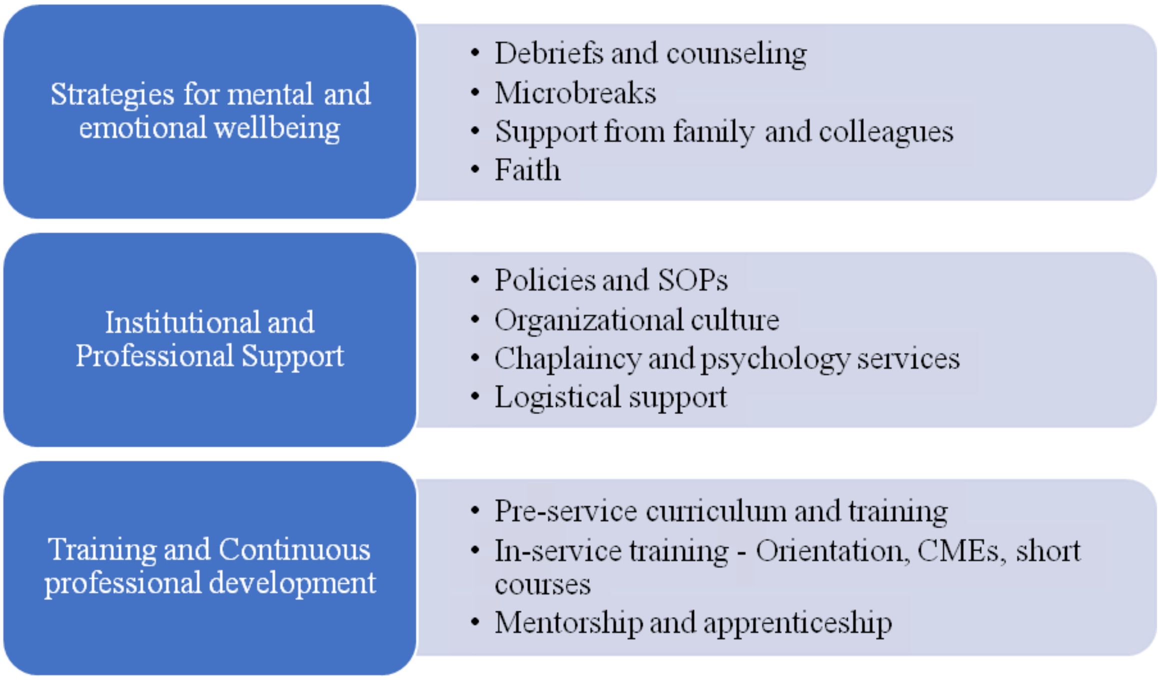
How Clinicians Can Be Supported in Their Role of Breaking Bad News

Themes:

- Strategies for mental and emotional well-being
- Institutional and professional support
- Training and development

Figure 4

How Clinicians can be Supported



Theme 1: Strategies for Mental and Emotional Well-being

Debriefs and Counselling. *Debriefs were reported to be important. They are often done in teams with good results, but not all participants were certain that they took place in their various departments.*

“Teams do need debriefing. We probably don't realize the kind of psychological impact it's having on us as healthcare teams…need some debriefing of some sort on a regular...” P12

“We had a session with one of our consultants about debriefing and why it's important. But I'm not sure many of the teams I have ever worked with have really done it.” P10

“We talk about the need for therapies, but there are no institutions to push people to actually go there. Yes, we know the importance, but are we, or you, even given the time to go and see that person? Like? Is it made like a policy?” P12

Another participant emphasized the importance of individualized debriefing and counselling sessions, rather than relying on team debriefing.

> *"We did it, like, twice, but I felt it needed to be individualized." P4*

Some participants felt the debriefs could be better. For instance, they should include affirmation and appropriate self-disclosure to facilitate healing, and they should be held more readily and frequently.

> *"…when you're so in the gutter, like with indecisiveness and guilt and all that, it would help somebody to tell you - you have done a good job. Those words are so simple, but they can make such a difference." P12*
>
> *"… just talking to them and then telling me their experiences…it did help me cope. That same night, we were on call and ended up doing even more CSs. But I think that support system really helps, especially if you're looking at it from a clinician's point of view, it does help a lot." P14*
>
> *"...I feel you need help, like instant, not waiting for a debrief that is scheduled…"P4*

Some participants expressed the need to differentiate and prioritize debriefs over audits.

> *"…the consultant called me to tell me what I should have done, I was like, ... Can you tell me this tomorrow? I'm not registering what you're saying...I don't remember to this day what that consultant said. I was not in the frame of mind to hear…" P12*
>
> *"Sometimes it's not a debriefing. It's as if someone is questioning you. Why this was not done…instead of debriefing, it becomes as if you are being pinned in it (widespread murmurs in agreement), so it makes it very …"P20.*
>
> *"… there is a difference between debrief and audit. (3 others chime in agreement). The audit should be done a bit later. We jump to audits before debriefs… we have moved away from the blame-ish kind of game, but it's somehow subtle. But I think I've made mistakes sometimes, and I know that*

you don't have to come in again. When I own up during the debrief session, it will make even the audit easier." P11

"Yeah... give me psychological first aid first."P12

Micro breaks

Taking small breaks after a difficult session should be encouraged, as participants reported that it helps clear the mind and boosts productivity thereafter.

"You can't just finish breaking the news, then immediately you are being given a patient. Maybe 20 or 30 minutes, just clear your mental space. Just try to bring yourself back, because it can have catastrophic consequences." P16

"So maybe if there could be a way that you could just take a break a bit and just relax…" P18

"You'd rather just get out there, get fresh air, and come back to the patient rather than giving your bare minimum." P19

Social support. *Participants reported seeking support from their colleagues and family members to help them cope with the effects of breaking bad news.*

Colleagues

"We try to debrief after that. That's why I'm talking about tea, so you have tea and try to talk about it." P20.

*"If your environment allows. Like **** said she will go talk to people. **** said that he will get the whole team and they will discuss it."P16*

Family

"You go home, you feel sad, you cry, you call your parents." P1

"My husband is my therapist, unfortunately (two others chime in agreement)" P12.

Faith. *Some participants reported that their faith in God was the source of their support. They valued the freedom to pray, as well as the spiritually-directed activities within the hospital – particularly bible study.*

*"…the only thing that you cling onto now is faith."*P12

"We get to the hospital, and we go to pray; we go for Bible study for a whole hour. That is such a privilege, like having such a platform." P19

"You just tell the Lord, here Jesus, carry me. Yeah. You just go praying" P11.

"We tried praying, and nothing worked for me on that day. I really felt disappointed." P6

Theme 2: Institutional and professional support

Standard operating procedures and policies. *Participants reported they found some policies helpful – for instance, the policy requiring the presence of a chaplain when breaking bad news of bereavement. Some gaps that can be filled with policy guidance include the need to clarify who breaks bad news of death to a family of a patient who dies during call hours - should it be done by the primary team or the call team? Another policy gap was the need for policy reinforcement of seeking professional psychological support when needed.*

"We already have the policy of chaplain" P1.

"There is a bit of confusion there. You have to bear the news and tell the family, yet you have not been seeing this patient...you can't really understand how...so it really is something that needs to be worked upon." P7

"…we talk about the need for therapies, but there are no institutions to push people to go there. Yes, we know the importance, but are we, or you, even given the time to go and see that person? Is it made like a policy? Like, after this, you should go and see them and bring a report that you actually saw this." P11

Workload and expectations. *Participants reported that they would appreciate breaks to help them deal with the effects of breaking bad news.*

"Tomorrow you're not supposed to be at work…abroad, you are even given time off, like most people are given time off to go and just do, and it's a must-debriefing. Here in Kenya, or rather in Africa, who has time for you to go and debrief? P14

"You are supposed to go back to work, as you definitely have other patients you are supposed to take care of," P20

Multidisciplinary teams and teamwork. *Some participants highlighted the need to have someone else with them when breaking bad news. This could be a senior colleague, members from other relevant teams, or even just one other colleague, not necessarily a fellow clinician.*

"a chaplain or clinical psychologist, someone who can help …even just another person in the room, that for me has been of great help." P23

"And we try to approach it as much as possible as a multidisciplinary team. So, we have a palliative team on board. We have oncology on board. We have chaplaincy on board, clinical psychology, we try to get as many teams that will support the patient beyond that family conference." P23

"I wish you could get even in outpatient the same kind of team put up together like the way it is in in-patient...like you have to have a psychologist…a chaplain...palliative…you have a big team. I guess it's possible…" P26

Chaplaincy. *Participants reported that the presence of a chaplain was important in helping support both parties when breaking bad news.*

"At some point, I just sat in the tea room and I was like, I think I just need a chaplain for myself." P12

"I just call the chaplain… where I give the medical facts, they come in and help with faith and prayer. That makes it easy," P12.

"We had to involve like a chaplaincy team, you know, and she felt so let down by God, and by us…" P11

"We have chaplaincy on board…will support the patient beyond that family conference" P23.

This support was, however, not readily available in the outpatient department, and some participants felt it would be better to have it there too.

"And oftentimes in the clinic, it's difficult to have chaplaincy, although, when I'm on the inpatient side, the last time I remember I was able to get chaplaincy on board" P21.

"I wish you could get even in outpatient the same kind of team put up together like the way it is in in-patient...like you have…a chaplain…" P26

Provision for psychological support

Participants expressed the need for psychologists to play a stronger role in supporting them in delivering difficult news. Some suggested having psychologists present during these sessions, while others felt that there should be more awareness about the availability of psychologists specifically for staff. Additionally, they suggested simplifying the process of accessing a psychologist, as the current requirement of activating their medical records file was seen as a barrier for some.

"Do we have staff psychologists? Maybe that can help…How do I get an appointment...we need that sensitization." P11

"…having psychological support. The hospital can make it easier...it's not like I have to go and open a file" P12

"We learned that there are people you can talk to. So, later, we reached out to someone, and they assisted us."P7

"I think it would be prudent …for someone in psychology, to also be present.

for patients who need to be explained to about this chronic illness…poor prognosis…when you need to talk to families about the patients who died…." P15

Physical and logistical support

One participant highlighted the need for designated spaces for family conferences and breaking bad news.
"…a space where we can easily have these conversations. Because many times you're trying to find a place, you're moving people in the tea room to create a space, like with a designated space that can be special for having these conferences," P23

Organizational culture. *The participants believed the hospital's culture was very supportive as it allowed them to have open discussions on their experiences. The spiritual practices that are part of the institutional culture were also cited as beneficial to clinicians as they cope with breaking bad news.*

"*Because our culture is so supportive. I mean, here we are having this conversation, which would not take place at a hospital with a bad culture." P25*

"I was thinking about how we have that environment. We head to the hospital, where we pray and attend Bible study for a whole hour. It's a privilege to have such a platform. That is a conducive environment, allowing you to express yourself to grow... but then if your environment is not allowing, it limits how we, as the health workers, are able to deliver that, that good care..." P19

Theme 3: Training and Development

Pre-service training. *There was an expressed need to have better training in breaking bad news, beginning in the medical schools and colleges.*

"*When I was in sixth year in medical school, we had a session with one of our consultants about debriefing and why it's important" P10.*

Orientation. *Proper orientation that adequately prepares new staff for their duties, including how to break bad news and where to get the help they may require.*

"When we come for... a group comes for the internship, I think the first CME should be about breaking bad news." P1

"We have a session for every intern, at least for the first week, or have it completely incorporated in our orientation, make our work a bit easier, and it would really go a long way." P4

"...the palliative team...were planning to take us through Breaking Bad news. Yeah, so it was really, really a good initiative, noting that they also noted that we have not been taken through that." P7

In-Service Training and Continuous Professional Development

Some participants expressed the need for continuous medical education programs on breaking bad news and challenging cases that others may have previously struggled with, aiming to enlighten others. Short courses that help build skills around breaking bad news should also be embraced.

“There is more that is needed in preparing the younger doctors who are coming on how to do this.”P23

“School, yes, but on the ground too...periodically. Revisit” P12

“It does not prepare you 100% but to have some tools in your belt other than this informal training through apprenticeship”P11

Mentorship and Apprenticeship

The role of learning from one another and seniors was lauded. Participants appreciated that working with various role models helped them learn and design their own style of doing it. Having a mentor present offered support to beginners who would sometimes get overwhelmed.

“*Preparation sometimes is, when you see your seniors (group agrees), how they handle it, you learn a thing or two.” P13*

“…it was my first time, I was confused and scared. But I was lucky because I had someone senior to me, who took over because he saw I was shaking.”P4

“*That is me now. When I was with them earlier on, it would have been great to have a senior, someone more knowledgeable and experienced to guide the conversation.” P27*

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter contains the discussion, conclusion, and recommendations of the study.

5.2 Discussion

This study showed that clinicians are ready to share their experiences for a perceived gain. This could help them cope with their experience through talking it out, appraisal and/or affirmation. One readily opens up to people they are comfortable with – mostly colleagues and peers. However, some may be reluctant to do so in a formal therapy session or where negative appraisal may arise. This is consistent with a study done in Norway, in the setting of psychotherapy, where various explanations were given for struggling to open up (Solberg Kleiven et al., 2023). The findings also agree to some extent with avoidance as a coping mechanism that clinicians often employ (Francis & Robertson, 2023). There were no clear racial differences among participants' readiness to talk about their experiences in this study, contrary to views held by Farber (2003) that black individuals tend to be more reticent. This may have been due to the unbalanced representation of the different races or to acculturation.

Bad news was generally described as information that alters the recipient’s view of their life, in keeping with the widely accepted definition by Buckman (1984). The aspect of bad news being determined by the patient also came out strongly. This was often in agreement with the clinician, but in some instances, it was received much better than anticipated due to value-judgement misalignment as proposed by Messerotti et al. (2020). The participants also highlighted the varied nature and magnitude of bad news, and thus the need to be sensitive and empathetic when sharing any form of information with a patient and/or their relatives. By and large, news about failed interventions, poor prognosis and introduction of palliation were the most difficult of news to share. This is in keeping with findings in Turkey, Italy, South Africa, and Togo (Anuk et al., 2022; Ganca et al., 2016; Kpanake et al., 2016; Messerotti et al., 2020). It was surprising that some patients considered being referred out or transferred out as bad news. This might be due to their disappointment in not having access to a particular service or services at their preferred hospital. However, some patients thought it was a sign that they could not be helped.

When it comes to preparation for breaking bad news, the earliest formal preparation is expected to take place as one is being prepared for other roles that a clinician is expected to play once they qualify. This study revealed a big gap in this area. A mere 27.3% of all the participants had received formal training in breaking bad news at the time of this study. It was almost unanimous that the preparation in school – whether at the clinical medicine level or medical school – was deficient. There was great variation in this area – from some citing there was absolutely nothing in their curriculum to prepare them to break bad news, to those who acknowledged there was some content, though very shallow, not practical, and not emphasized. This finding is in agreement with a big study conducted in 174 institutions in 40 countries across the world that found only 33.4% of practitioners had received formal training in breaking bad news (Alshami et al., 2020).

This leaves many at a loss when they have to do it, especially for the first time during an internship. They thus rely a lot on apprenticeship. In this study, the 73% who had not received any formal training in breaking bad news represented the majority of clinicians across all four cadres. It is thus not a cadre problem. Continuous professional development has also neglected this area. Another study done locally, at one of the national referral centres, found that almost 70% of the post-graduate students had neither received any formal training nor observed a faculty member break bad news (Chumba et al., 2022). This begs the question, how and from whom should students learn to break bad news? Does low self-efficacy among clinicians and faculty in breaking bad news contribute to the lack of proper training for students, further sustaining this vicious cycle? On a case-by-case basis, the participants shared varied experiences. Some took time to prepare, while others said they never really prepared.

In the setting of this study, a chaplain should be present when news of bereavement is being shared. Many learn to do this during their first few days in the facility. There is also a provision to call for support from the palliative team for family conferences, especially regarding terminal illness, poor prognosis, and/or change in goals of care discussions. This is commendable. However, given the varied nature and magnitude of bad news, coupled with the unpredictability of cases that one will come across in the fast-paced activities of the day and the limited number of personnel in chaplaincy and palliative teams, the clinician will often have to go it alone or tag a colleague along if lucky. The inpatient teams seem to have an advantage over the outpatient settings. They reported having a bit more time to review medical records, organize family conferences, assemble multidisciplinary teams, and have unhurried discussions.

Their counterparts in the clinics and emergency departments reported not having the luxury of time and access to members from other disciplines in the fast-paced settings. One participant, however, shared his approach to anticipating and preparing for bad news at a scheduled clinic – by keeping a log of who he expects to come for review and seeking out their results beforehand. A systematic approach, as illustrated in the inpatient and scheduled clinic approach, was reported to help clinicians and patients have a better experience. This agrees with a study that showed a methodical approach significantly contributes to a better experience for both parties (Messerotti et al., 2020). It is still possible to have a methodical approach even when there is limited time to prepare. This is, however, not always the case.

When discussing the various aspects that influence the experience of delivering bad news, it was found that these can be largely categorized into three groups: patient, clinician, and environmental aspects. The impact of these aspects on clinicians aligns with existing literature. Most of these aspects are potentially modifiable, especially those related to the provider and the environment, and would require action at various levels. It would involve clinicians reflecting on and addressing internal aspects, as well as improving their skills in specific areas (Alshami et al., 2020; Anuk et al., 2022). Developing the habit of adequately preparing for each case of delivering bad news, as much as possible, would also improve the experience by enhancing one's self-efficacy.(Chumba et al., 2022; Francis & Robertson, 2023; Messerotti et al., 2020).

Aspects such as the influence of dual relationships, faith conflict, and the impact of stacking bad news are not addressed much in the literature. However, according to Kaye (2020), the faith question cuts across religions and belief systems, and different people have different ways of interacting with and expressing spirituality. In the face of human suffering, a medical doctor has to walk that journey and find the point of intersection between their practice and faith (Kaye, 2020). The environmental aspects that can be modified to improve the clinician’s experience of breaking bad news include having designated physical spaces for such discussions, enhancing teamwork to support one another, and cultivating a supportive culture (Anuk et al., 2022; Francis & Robertson, 2023).

All participants acknowledged that breaking bad news affected them to a significant extent. This aligns with the postulation that the conveyor of bad news is right at the centre of it (Anuk et al., 2022; Berger & Ribeiro Miller, 2022). The effects began before, persisted through, and some remained after the session, some months later. These effects transcended to affect productivity at work and quality of life outside of work. This is not surprising as the foregoing literature has shown that one's philosophy of life, values, spirituality, ethical beliefs, and practices are often affected by these experiences (Anuk et al., 2022; Fontes et al., 2017; Francis & Robertson, 2023; Messerotti et al., 2020).

To cope with the effects of this role in their clinical practice, clinicians have recognized their sources of support and have developed mechanisms around them. Seeking social support from colleagues, friends, and family is one of the key benefits, mainly to talk it out. A meta-analysis conducted showed that talking it out was key to coping well, and that oftentimes, people had to do it several times to get it out (Francis & Robertson, 2023). Maintaining healthy relationships both at work and at home is thus paramount to a clinician’s well-being. Others included faith, intellectualization, sublimation, and self-reflection. Faith, self-reflection, and self-evaluation have been widely used and recommended as coping mechanisms(Francis & Robertson, 2023; Keaggy, 2010; Messerotti et al., 2020). Some clinicians revealed the tendency to adopt some unhealthy mechanisms, such as avoidance and disengagement, but they acknowledged that these are not the best strategies. Other maladaptive mechanisms that were not brought up in this study include the use of substances, dark humour, and detachment to evade or numb emotional involvement and psychological pain(Francis & Robertson, 2023; Søvold et al., 2021). This may have been partly influenced by the study's setting as a faith-based institution.

Clinicians can be supported in their role as the conveyers of bad news through proper equipping through training and mentorship, providing psychological support, and conducive work environments. Considerations for a healthy work environment as revealed in this study was an organizational culture that encourages teamwork, provides the necessary resources for the work including standard operating procedures, physical spaces, expertise from multiple disciplines like psychology, palliative, chaplaincy – and upholds the humanity of the clinician – appropriate workload, allowing for necessary breaks and free interact to allow them to share their experiences and be appropriately vulnerable without fear of victimization. Micro breaks have been found to be healthy and help boost productivity (Prior & Martelli, 2021).

Debriefs are a great way to help clinicians cope with human suffering and breaking bad news (Francis & Robertson, 2023). This can be done at the departmental or team level. This study revealed that clinicians appreciate both immediate and periodic debriefing sessions, with some preferring immediate ones. However, there was concern that there may be times when the tendency is to rush to clinical audits at the expense of the clinician's well-being. Whilst clinical audits were acknowledged to be helpful as well, there is a need to take care of the clinician's psychological needs before professional and system improvement, and to run the audits objectively.

5.3 Study Limitations

The call for deep vulnerability was an anticipated limitation. This was mitigated by the reassurance and reminder to opt out whenever one felt unable to continue. This also jeopardised exhaustive exploration of some themes, which was mitigated by the use of code saturation, as opposed to meaning saturation. Reticence cannot be confidently ruled out as a reason for no-show for the potential participants who failed to turn up on the agreed time without communication.

The study explored the general experience of clinicians and did not necessarily delve into the unique experiences of different specialties and subspecialties. Future studies can explore these aspects.

5.4 Conclusions

Breaking bad news is a fundamental aspect of clinical practice and can pose a significant challenge for clinicians. It is vital for clinicians to understand the diverse nature of information that may be perceived as bad news from a patient's perspective. Clinicians should be well-prepared and highly skilled in delivering such news while also promoting teamwork and multidisciplinary approaches whenever possible. It is also important to continually address the aspects that can be modified while building mechanisms and resilience to deal with the non-modifiable ones that influence their experiences. Some of these aspects that are often overlooked include the effect of stacking bad news, the challenges of dual relationships and the role of faith (Both the recipient’s and conveyor’s) in breaking bad news. Clinicians should be aware of these and develop strategies to effectively handle them. Additionally, clinicians should cultivate self-awareness, engage in reflection, and acknowledge their vulnerabilities when breaking bad news. They need to adopt healthy coping strategies and seek support while also addressing any unhealthy coping mechanisms.

Furthermore, institutions should play a proactive role in supporting clinicians in their role of breaking bad news. Medical training curricula should incorporate the skills of breaking bad news and self-care to adequately equip future clinicians for this integral role. Health facilities should proactively prioritise the psychological well-being of clinicians through allowing for micro-breaks, providing debriefing and counselling services, as well as building multidisciplinary teams - incorporating chaplaincy and psychology where possible. Clinician-centred support will help them operate optimally and have a positive impact on patient care, teamwork, job satisfaction, and ultimately, the healthcare system.

5.5 Recommendations

5.5.1 Policy Recommendations

Training

Given the significant role that good preparation has in equipping clinicians to properly break bad news, as highlighted in this study, it should be emphasized. There is a need to strongly incorporate breaking bad news in pre-service training in medical schools and colleges. Health institutions should also have a framework for orientation, apprenticeship, and mentorship in this area.

Institutional Policies

Institutions should establish policies and standard operating procedures to guide the handling of bad news – the who, when, how, and what. In the study location (AICKH), for instance, the policy on chaplaincy and multidisciplinary approach was reported to be helpful to the primary teams (clinicians) and is highly recommended. These multidisciplinary teams should also be made more available in the outpatient settings. In AICKH, the need to further define who is responsible for breaking bad news when a significant event occurs during call hours and the attending team is not the primary team, was highlighted.

Clinician-Centred Support

Work environments should make provisions for logistical and psychological support to clinicians to facilitate their work of breaking bad news. This includes protected physical spaces for holding sessions that are comfortable and guarantee privacy, flexibility in time to allow adequate time for and micro breaks after breaking bad news, and easy access to psychology services, among others.

Support to clinicians on breaking bad news should be focused on what they consider necessary. Therefore, dialogue should precede any initiatives aimed at offering support to prevent a skewed focus on performance, which could compromise clinicians' well-being.

5.5.2 Recommendations for Future Research

i. Future research should consider an ethnographic study to develop further and enrich the literature on this topic, especially in the African setting.

ii. More studies focusing on underexplored areas—particularly the impact of dual relationships in breaking bad news, the intersection of faith and clinical practice, the impact of stacking bad news on clinicians, and the attitude of patients (and their families) towards referrals and transfer of care should be encouraged in our setting.

iii. Similar studies should be conducted in varied settings, including health facilities of levels II-IV, non-faith-based institutions, non-academic institutions, and other academic institutions.

iv. Specialty-specific studies should also be considered to help understand whether there are any experiences and factors unique to particular disciplines.

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APPENDICES

Appendix 1: Data Collection Tools

Participant’s Characteristics Data

[] Male [] Female

Age (in years): [ ]20-30 [ ]30-40 [] 40-50 [ ]50-60 []> 60

Cadre: []Intern[] RCO [] MO or Resident [] Consultant

Years of practice: [] 0-2 [ ]3-5 [] 6-10 [] 10-15 []>15 years

Have you ever worked/are you working away from your country of origin? [] YES [] NO

Have you received any training in communication skills? [] YES [] NO

Have you received any training in breaking bad news? [] YES [] NO

Have you received any training in counselling? [] YES [] NO

Have you received any training in palliative care? [] YES [] NO

The above form is available via the following link https://docs.google.com/forms/d/e/1FAIpQLSec66OP6U4SjK2ZncgtgzLVBYY9L6Md59roBiEoSASp74WYWQ/viewform?usp=share_linkor via the following QR code

Semi-Structured Interview Guide

1. Do you feel ready to engage in discussions about your experiences with breaking bad news?
2. How would you define bad news in your clinical practice?
3. Could you share an experience (s) you have had of breaking bad news?
    a. What was the circumstance/scenario?
    b. How did you prepare for the session (s)?
    c. How did you conduct/normally conduct the actual exercise of breaking bad news? (How did the session go?)

d. What did you do thereafter?
e. How did this experience make you feel? (*Do different experiences evoke different feelings each time*?)
f. What factors made it easier or (more) difficult?

4. How can you be better supported (in the role of breaking bad news) in the future?
5. Is there something else you would like to add/comment on?

Appendix II: Informed Consent

Informed Consent Form

STUDY TITLE: EXPERIENCES OF HEALTHCARE WORKERS IN AIC KIJABE HOSPITAL IN BREAKING BAD NEWS.

PI: SHEILA SISELA

Affiliated Institution: KABARAK UNIVERSITY & AIC KIJABE HOSPITAL
Co-investigator____________________ Affiliated Institution(s)_____________________

INTRODUCTION

You are invited to participate in this research study being undertaken by the above-listed investigators. This form will help you gather information about the study so that you can voluntarily decide whether you want to participate or not. You are encouraged to ask any questions regarding the research process, as well as any benefits or risks that you may accrue by participating.

After you have been adequately informed about the study, you will be requested to either agree or decline to participate. Upon agreeing to participate in the study, you will be further requested to affirm that by appending your signature/thumbprint on this form. Accepting or declining to participating in this study does not in any way waive the following rights, which you're entitled to:

a) Voluntary participation in the study;
b) Access to services which you're entitled to
c) Withdrawing from the study at any time without the obligation of having to give an explanation, unless you are willing to.

A copy of this form will be provided to you for your own records.

Should I continue YES/NO __________

This study has been reviewed and approved by the Kijabe Research Ethics Committee.

What is the Purpose of the Study?

The main reasons for conducting this study are:

i. To examine the readiness of healthcare workers to discuss their experiences of breaking bad news

ii. To explore the experiences of healthcare workers in breaking bad news

iii. To find out ways in which healthcare workers can be better supported in their role of breaking bad news.

In order to achieve this, you are requested to voluntarily answer question(s) and engage in a focus group discussion.

Who can Take Part in the Study?

Any clinical officer or medical doctor who has engaged in breaking bad news at any point in their training or practice shall be eligible to participate in the study.

At recruitment, those who, for one reason or another, will not be available in person during the study period shall be excluded.

There shall be four focus group discussions, each with a particular cadre of clinicians/ doctors.

In Case You Agree to Participate in the Study, What Will Happen?

This is what is going to happen once you have agreed to participate in the study:

First, you will be required to fill out a data collection sheet. No identifiers or personal information shall be collected.

Second, you will join other participants for a focus group discussion. Each focus group discussion will take about 90 to 120 minutes. The discussions shall be audio-recorded. Voice distortion and coding shall be used to hide your identity.

Third, a qualified and well-trained interviewer will ask you questions in the context of your cadre-specific focus group. This shall take place in a private space where you will feel comfortable. There shall be no coercion to respond to any question. The questions will be on the following areas:

- Understanding of bad news
- Experience of breaking bad news
- Ways in which you can be supported in the role of breaking bad news.

Last, you are requested to provide your contact details (phone number or any other reliable form of contact). This will help reach you in case new information regarding the study emerges. Another reason for requesting your contact details is in case you need follow-up psychological support.

The contact details you will provide shall remain confidential to the lead researcher (PI).

What Potential Risks are Associated with Participation in this Study?

Any research involving human subjects has the potential of imposing a number of risks/harms or

discomfort, including psychological, physical, emotional, environmental, cultural, etc.

The nature of this study may be a bit uncomfortable for some people. It is understandable for you to feel **not ready** to discuss your experiences. Should this be the case, feel free to decline participation.

Kindly tick the appropriate checkbox:

☐ I feel ready to participate in the study
☐ I do not feel ready to participate in the study

If you are not ready to participate, in what ways can you be supported?
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Privacy & Confidentiality

Privacy is the right of an individual to have some control over how their personal information/data is collected, used, and/or disclosed. Confidentiality is the duty to ensure information (data) is kept secret only to the extent possible/reasonable. Documents containing sensitive information shall be password-protected, and the audio recorders shall be kept under lock and key. Voice distortion and coding shall be used to disguise the identities of the participants.

In case you aren’t comfortable answering any of the questions during the interview because of feeling embarrassed or uncomfortable, it will be within your rights to decline. Otherwise, every measure has been taken to ensure that the interview is conducted in a private area with minimal to no interference so that you feel comfortable.

What Benefits are you Going to Accrue by Participating in the Study?

This research aims to raise awareness and foster an understanding of the lived experiences of healthcare workers in breaking bad news. This is an often-overlooked aspect that has detrimental effects when left unattended. We hope that the understanding gained shall inform better support structures and systems for the healthcare workers as they continue to engage in the crucial task of breaking bad news. The benefits of this shall positively impact not only the healthcare workers but their patients (and patients’ families), work environments, and the healthcare system as a whole.

At any individual level, participation in this study will help you reflect on and share your experiences, as well as hear other participants’ experiences. This will serve as a debrief and group therapy as well. There shall be basic counselling offered to participants who experience psychological/emotional distress in the course of the study.

What Will it Cost You to Participate in the Study?

The study will require you to give a significant amount of your time.

It will also require some level of vulnerability to share your experiences.

You shall also be required to refrain from disclosing what transpires during the focus group discussions to non-participants. This will help protect the privacy of other participants.

There shall be no monetary reimbursement for participating in this study.

In Case I have any Further Questions/ Concerns in the Future, Whom Should I Contact?

In the event that you need further clarification or questions regarding your continued participation in the study, feel free to contact the PI {Sheila Sisela – 0728499595; asisela@kijabehospital.org}.

In case of concerns regarding your rights and/or obligations as a research participant, do not hesitate to contact the secretary, KISREC on {KISREC contact}

What Alternative Options are Available to Me?

The decision on whether to participate or not is absolutely voluntary. You will be free to withdraw from the study at any point during the study without providing any explanation.

How Will the Findings of this Study be Communicated or Shared?

. Avenues shall be sought to disseminate the findings and recommendations to the Kijabe Hospital community and to healthcare workers in general through conferences and webinars. This study shall be submitted to Kabarak University and made available in the Kabarak University repository for your perusal. Publication shall also be pursued to make it available to many more healthcare workers across the globe.

Statement of Consent

I have comprehensively read the consent form,and/the information has been comprehensively read to me by the researcher. I have understood what the study is about, and all the questions and concerns that I had have been addressed clearly and concisely. The study benefits and foreseeable risks have been explained to me. I totally understand that my decision to participate in this study is voluntary, and I have the right to withdraw at any point during the study.

I freely consent to participate in this study.

Signing this form does not in any way imply that I have given up the rights I am entitled to as a participant.

I agree to participate in this research YES___________ NO____________

I agree to provide my contact details for follow-up YES___________ NO ___________

Participant’s Name ____

Participant’s Signature/Thumb print________________ Date _____________________

OPT-OUT FORM

Thank you for your participation thus far.

Having understood the intricacies of the study, you have chosen not to participate any further. We respect your choice. Kindly allow us to ask you two last questions:

My reason for choosing not to participate any further is because:

☐ I do not feel ready to discuss my experiences

☐ Other reasons

☐ Both

How can I be supported?

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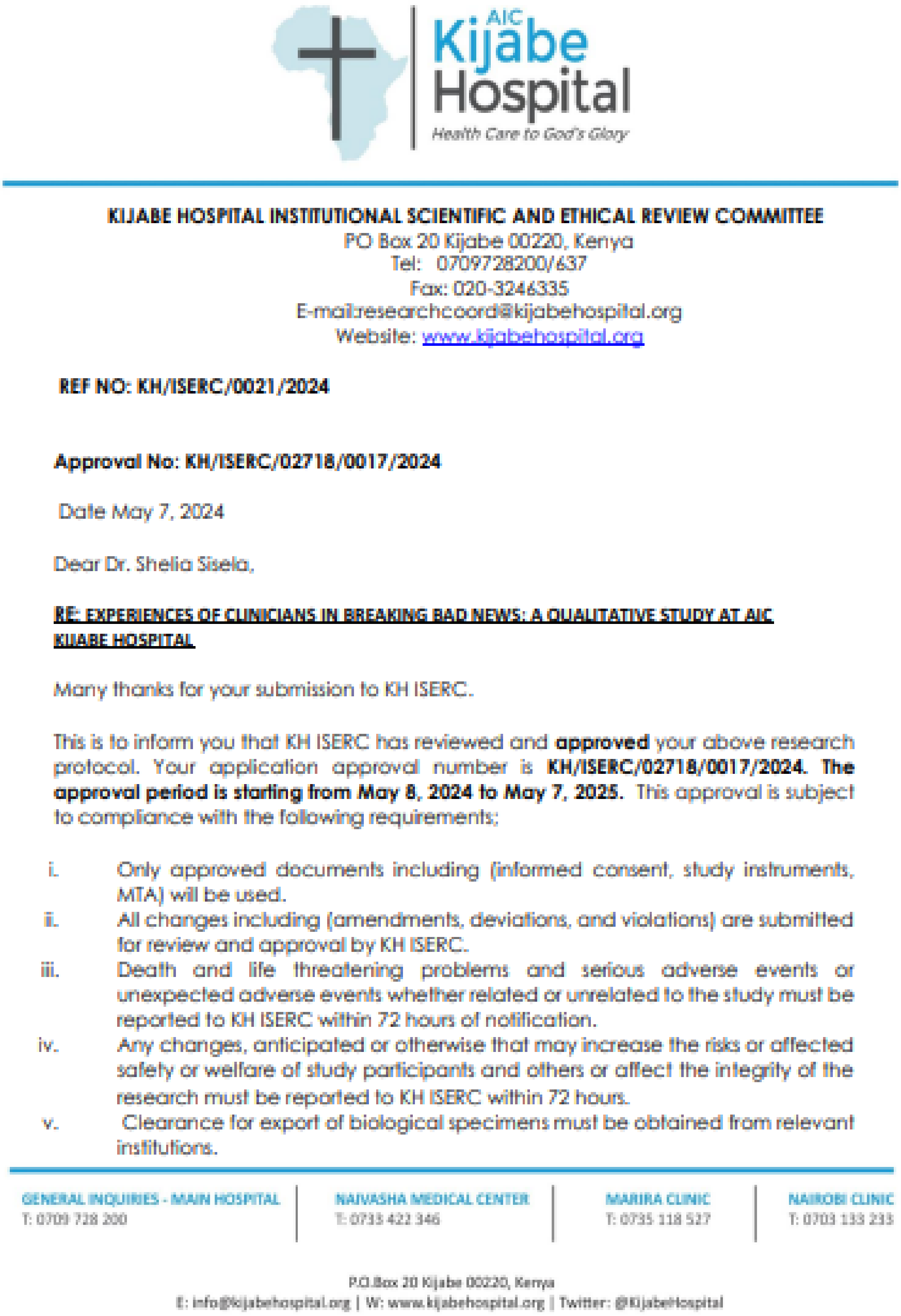
Thank you for your time and contribution.

Principal Investigator,

Sheila Sisela.

Appendix III: Ethical Approval from AIC Kijabe Hospital



KIJABE HOSPITAL INSTITUTIONAL SCIENTIFIC AND ETHICAL REVIEW COMMITTEE
PO Box 20 Kijabe 00220, Kenya
Tel: 0709728200/637
Fax: 020-3246335
E-mail:researchcoord@kijabehospital.org
Website: www.kijabehospital.org

REF NO: KH/ISERC/0021/2024

Approval No: KH/ISERC/02718/0017/2024

Date May 7, 2024

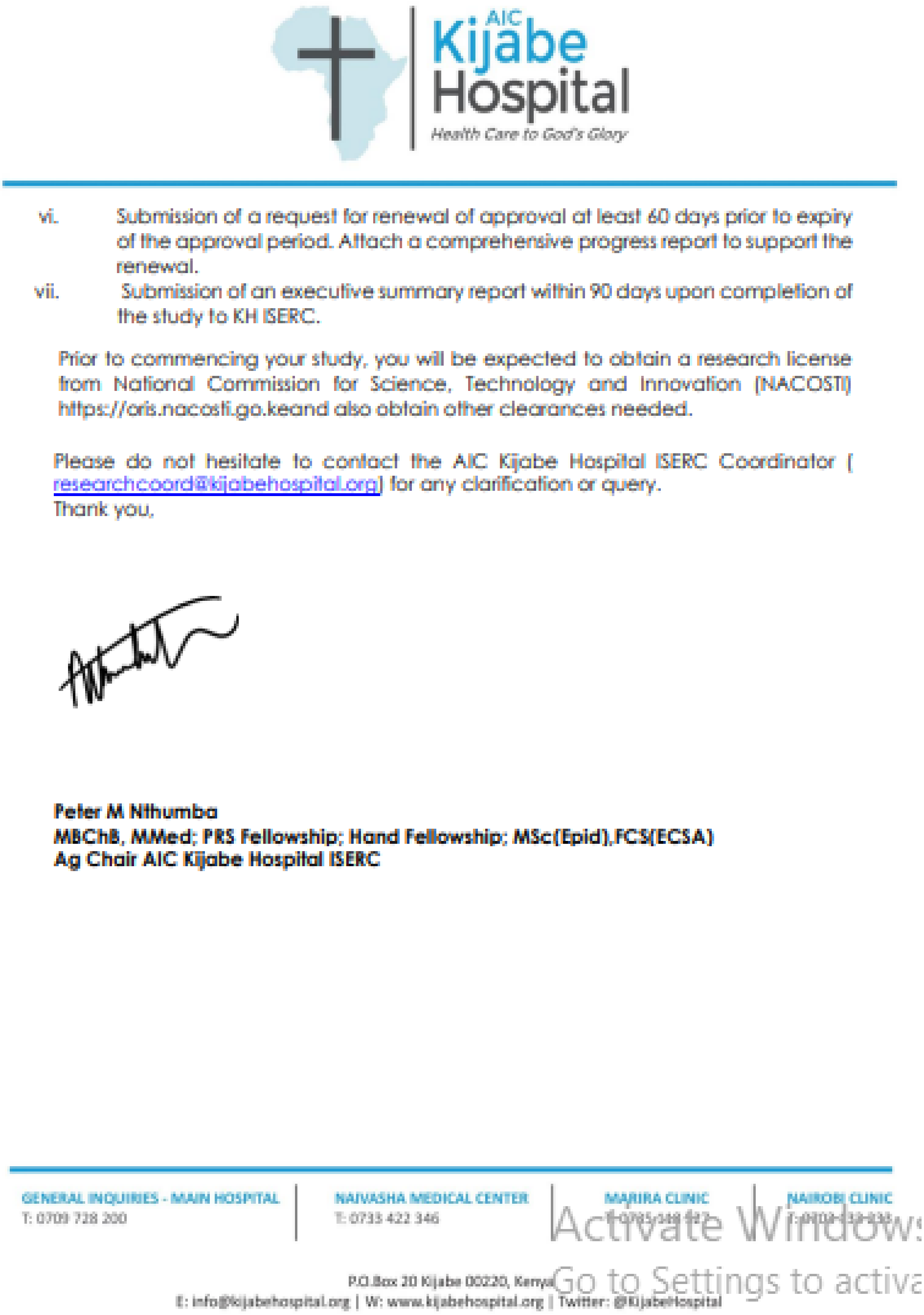
Dear Dr. Shelia Sisela,

RE: EXPERIENCES OF CLINICIANS IN BREAKING BAD NEWS: A QUALITATIVE STUDY AT AIC KIJABE HOSPITAL

Many thanks for your submission to KH ISERC.

This is to inform you that KH ISERC has reviewed and **approved** your above research protocol. Your application approval number is **KH/ISERC/02718/0017/2024. The approval period is starting from May 8, 2024 to May 7, 2025.** This approval is subject to compliance with the following requirements;

i. Only approved documents including (informed consent, study instruments, MTA) will be used.
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by KH ISERC.
iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to KH ISERC within 72 hours of notification.
iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to KH ISERC within 72 hours.
v. Clearance for export of biological specimens must be obtained from relevant institutions.



AIC
Kijabe
Hospital
Health Care to God's Glory

vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days upon completion of the study to KH ISERC.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.keand also obtain other clearances needed.

Please do not hesitate to contact the AIC Kijabe Hospital ISERC Coordinator (researchcoord@kijabehospital.org) for any clarification or query.
Thank you,

Peter M Nthumba
MBChB, MMed; PRS Fellowship; Hand Fellowship; MSc(Epid),FCS(ECSA)
Ag Chair AIC Kijabe Hospital ISERC

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Appendix IV: NACOSTI Research Permit

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY & INNOVATION

Ref No: 842815

Date of Issue: 23/May/2024

RESEARCH LICENSE

This is to Certify that Dr.. SHEILA ANJIWA SISELA of Kabarak University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Kiambu on the topic: Experiences of Clinicians in Breaking Bad News: A Qualitative Study at AIC Kijabe Hospital for the period ending : 23/May/2025.

License No: **NACOSTI/P/24/35713**

842815

Applicant Identification Number

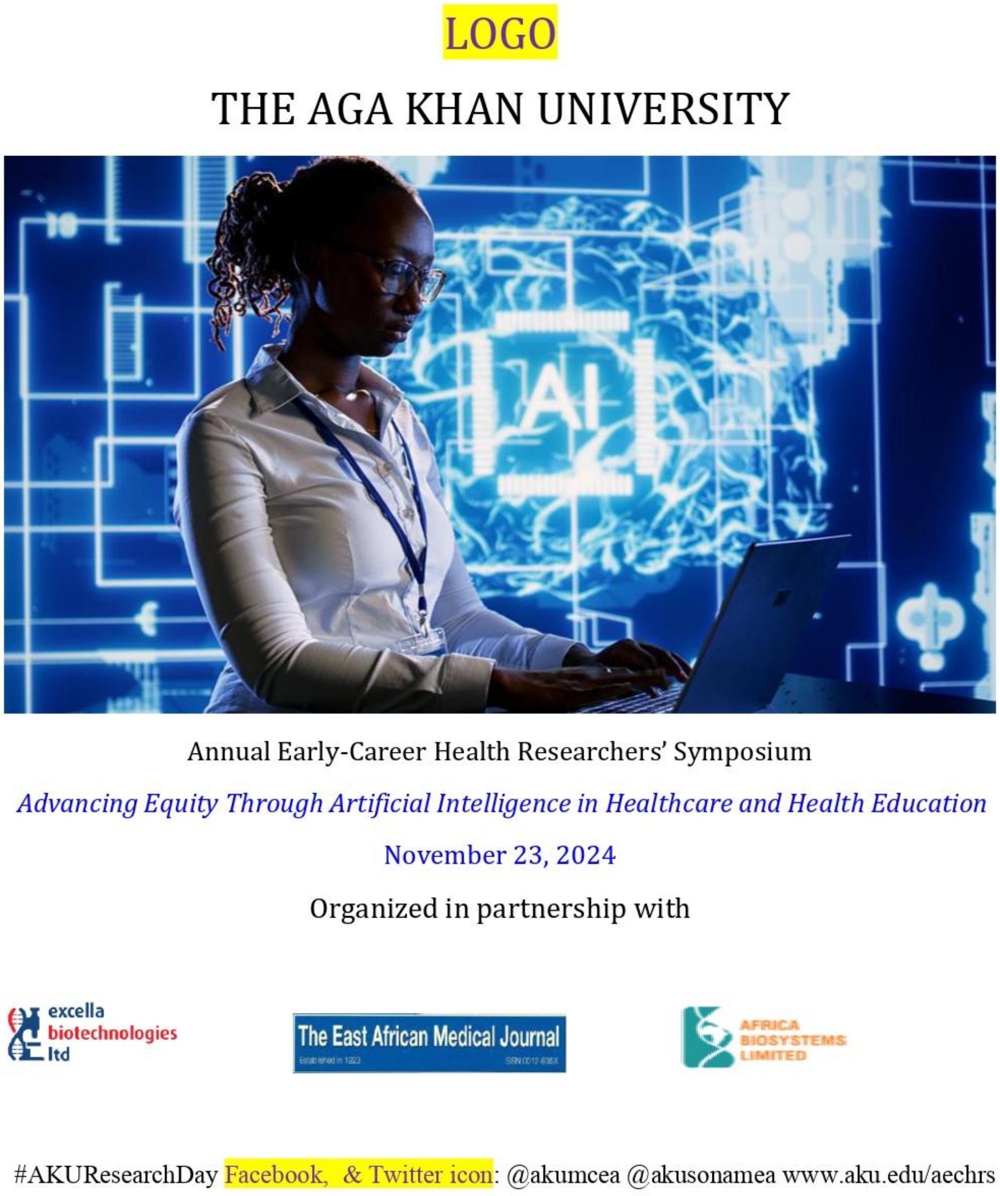
Director General
NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY &
INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document,
Scan the QR Code using QR scanner application.

See overleaf for conditions

Appendix V: Evidence of Conference Participation



LOGO

THE AGA KHAN UNIVERSITY

Annual Early-Career Health Researchers’ Symposium

Advancing Equity Through Artificial Intelligence in Healthcare and Health Education

November 23, 2024

Organized in partnership with

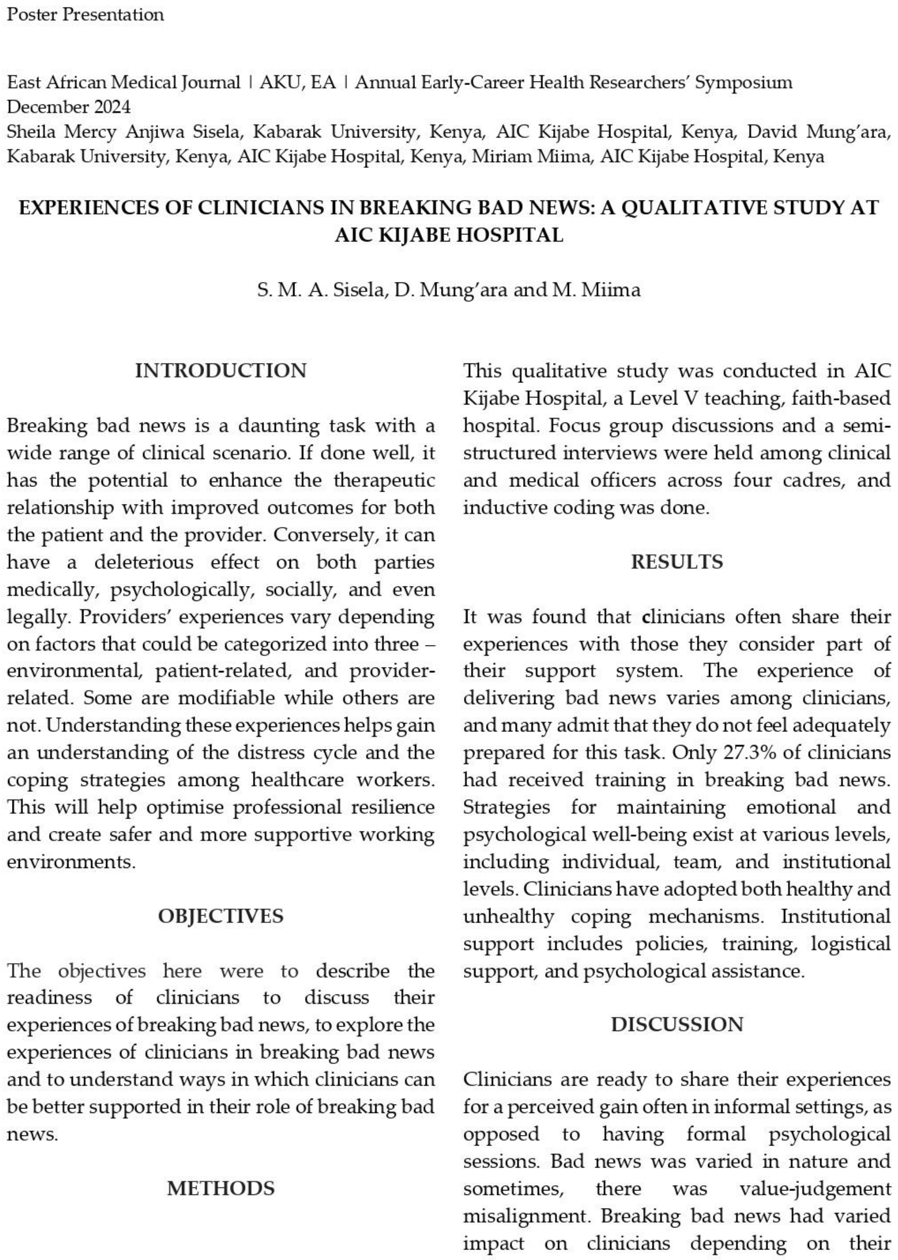
excella biotechnologies ltd

The East African Medical Journal

AFRICA BIOSYSTEMS LIMITED

#AKUResearchDay Facebook, & Twitter icon: @akumcea @akusonamea www.aku.edu/aechrs

Appendix VI: List of Publication



Poster Presentation

East African Medical Journal | AKU, EA | Annual Early-Career Health Researchers' Symposium
December 2024

Sheila Mercy Anjiwa Sisela, Kabarak University, Kenya, AIC Kijabe Hospital, Kenya, David Mung'ara, Kabarak University, Kenya, AIC Kijabe Hospital, Kenya, Miriam Miima, AIC Kijabe Hospital, Kenya

EXPERIENCES OF CLINICIANS IN BREAKING BAD NEWS: A QUALITATIVE STUDY AT AIC KIJABE HOSPITAL

S. M. A. Sisela, D. Mung'ara and M. Miima

INTRODUCTION

Breaking bad news is a daunting task with a wide range of clinical scenario. If done well, it has the potential to enhance the therapeutic relationship with improved outcomes for both the patient and the provider. Conversely, it can have a deleterious effect on both parties medically, psychologically, socially, and even legally. Providers' experiences vary depending on factors that could be categorized into three – environmental, patient-related, and provider-related. Some are modifiable while others are not. Understanding these experiences helps gain an understanding of the distress cycle and the coping strategies among healthcare workers. This will help optimise professional resilience and create safer and more supportive working environments.

OBJECTIVES

The objectives here were to describe the readiness of clinicians to discuss their experiences of breaking bad news, to explore the experiences of clinicians in breaking bad news and to understand ways in which clinicians can be better supported in their role of breaking bad news.

METHODS

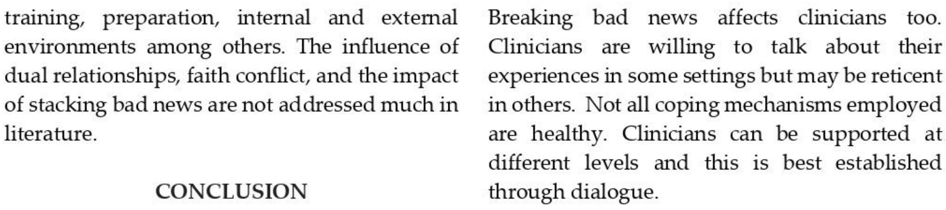
This qualitative study was conducted in AIC Kijabe Hospital, a Level V teaching, faith-based hospital. Focus group discussions and a semi-structured interviews were held among clinical and medical officers across four cadres, and inductive coding was done.

RESULTS

It was found that clinicians often share their experiences with those they consider part of their support system. The experience of delivering bad news varies among clinicians, and many admit that they do not feel adequately prepared for this task. Only 27.3% of clinicians had received training in breaking bad news. Strategies for maintaining emotional and psychological well-being exist at various levels, including individual, team, and institutional levels. Clinicians have adopted both healthy and unhealthy coping mechanisms. Institutional support includes policies, training, logistical support, and psychological assistance.

DISCUSSION

Clinicians are ready to share their experiences for a perceived gain often in informal settings, as opposed to having formal psychological sessions. Bad news was varied in nature and sometimes, there was value-judgement misalignment. Breaking bad news had varied impact on clinicians depending on their training, preparation, internal and external environments among others. The influence of dual relationships, faith conflict, and the impact of stacking bad news are not addressed much in literature.



CONCLUSION

Breaking bad news affects clinicians too. Clinicians are willing to talk about their experiences in some settings but may be reticent in others. Not all coping mechanisms employed are healthy. Clinicians can be supported at different levels and this is best established through dialogue.