Imad Khojah et al. Saudi J Er Med. 2024;5(3):175-181
DOI: 10.24911/SJEMed.72-1704670837



ORIGINAL ARTICLE

# Assessing preferences and sociodemographic influences on conveying bad news in an emergency department: a cross-sectional study at a Tertiary Hospital in Jeddah

Imad Khojah[1,2], Marshad A. Almutairi[2]*, Fatmah Alsomali[1,2], Essam W. Zarei[2], Ahmed H. Khan[2], Amjad S. Alshardy[2], Abdulaziz K. Alghamdi[2], Mohammed A. Alghamdi[2]

## ABSTRACT

**Background:** Breaking bad news encompasses conveying information that significantly impacts an individual's view of their present and future. In emergency departments (EDs), medical professionals often face the challenge of delivering distressing news. This study explored patient and family preferences for receiving bad news in the ED, considering sociodemographic factors such as education and gender.

**Methods:** This cross-sectional study involved 304 patients from the ED of King Abdulaziz University Hospital (KAUH) in Jeddah, Saudi Arabia. The participants were divided into four groups based on their gender and educational level. A *p*-value of <0.05 was considered statistically significant.

**Results:** Patients with a high education level strongly preferred receiving full details regarding their medical condition and desired to be told privately. Considering gender differences, female patients preferred to communicate with their physicians through a formal and gentle approach. Whereas, male patients preferred receiving bad news through one of their family members. In addition, 51.3% of the participants (*n* = 156) indicated that they preferred their family members to be in a nearby waiting room while they were undergoing cardiopulmonary resuscitation (CPR).

**Conclusion:** When emergency physicians deliver bad news to their patients or the patients' families, it is advisable to consider factors such as the patient's gender and educational level. Sitting face-to-face in a separate room was reported as the best way to deliver bad news to family members. Most importantly, patients wanted to learn more about their medical condition and have their family members waiting nearby while CPR was performed.

**Keywords:** Emergency department, break bad news, preferences

## Introduction

In the emergency medicine field, medical professionals frequently encounter challenges in determining the optimal method for communicating distressing information to patients [1]. The concept of breaking bad news (BBN) was articulated by Robert Buckman, who defined it as any information that significantly and adversely affects a person's perception of their present and future [2]. In the emergency department (ED),

**Correspondence to:** Marahad Abdullah almutairi
*Faculty of Medicine, King Abdulaziz University, Jeddah, Saudi Arabia.
**Email:** marshad34035@gmail.com
*Full list of author information is available at the end of the article.*
**Received**: 07 January 2024 | **Accepted**: 19 April 2024

medical practitioners routinely engage in delivering distressing news. This facet of medical care is universally acknowledged as an intricate and formidable challenge [1,3,4].

Patients' preferences for receiving distressing news differ from those of doctors. Simultaneously, articulating information regarding disease prognosis, progression, and anticipated life expectancy in plain language is challenging. Consequently, many practitioners have reported difficulties in accurately delivering this information, highlighting the need for training in this area [5,6]. Effectively conveying difficult news to patients appears closely linked to their feelings of anxiety and stress, their ability to cope and be satisfied with the care they receive, and overall health outcomes. In this era of evidence-based medicine, healthcare must be restructured with a patient-centric approach. Physicians should be equipped to deliver distressing news while accommodating patients' preferences [3,4,7]. In some instances, doctors encounter challenges such as time constraints, disruptions in circadian rhythms, and unforeseen circumstances, which can make them susceptible to distraction and emotional strain. These occurrences underscore the vital role of efficient patient and family communication as an essential skill in emergency medicine. In essence, effective communication is imperative within the healthcare industry. The cornerstone to addressing intricate challenges in clinical practice lies in adept communication skills, enabling the delivery of a clear message even in unfortunate circumstances. BBN is more than just giving information; it involves managing the patient's emotions and their loved ones' reactions [8-10]. There is no universally prescribed approach for how patients and their family members should receive distressing news. This can differ depending on factors such as the patient's level of education, gender, occupation, and cultural background, leading to variations in the preferred communication style [11,12]. For instance, patients in South and East Europe and China preferred to receive comprehensive information about their medical condition [11,13], whereas, in Turkey, patients' relatives attempted to conceal the illness from the patient [4].

A Turkish study involving 760 patients revealed a preference for waiting in a nearby room rather than witnessing cardiopulmonary resuscitation (CPR) procedures [4]. A study in Bangalore, India, surveyed 127 patients from a tertiary referral hospital's medical oncology clinic. Most participants expressed a strong preference for involving their family in discussions about their cancer diagnosis and underscored their desire for detailed information about their medical condition [14]. A study in Iran assessed 130 patients' perspectives. The general consensus among the participants was that the most experienced physician should provide a thorough explanation of their medical condition. They also stressed the importance of receiving upsetting news in a timely and calm manner, as opposed to the chaotic settings usually found in hospital corridors or emergency rooms [3].

To the best of the authors' knowledge, research on emergency patients' preferences for receiving bad news is lacking in Saudi Arabia. This study aimed to examine how patients and their families prefer to receive bad news in the ED. It also assessed the effect of sociodemographic variables on these preferences.

## Method

### *Study design*

This was an interview-based cross-sectional study, conducted at King Abdulaziz University Hospital (KAUH) in Jeddah, Saudi Arabia, from June to August 2023. The study included 304 participants who met specific eligibility criteria. The research objectives were explained to the participants, and data were collected through in-person interviews in the ED. The inclusion criteria were any patient aged ≥18 years or any family member of a patient admitted to the ED at KAUH. Patients or relatives who declined to participate were unable to speak or communicate, had cognitive impairments, abused drugs or alcohol, or required immediate medical assistance were excluded. Participants were divided into four groups based on level of education and gender: Group 1 included those with a university education and above, Group 2 included participants with a high school education and below, Group 3 comprised male participants, and Group 4 consisted of female participants.

### *Data collection instruments*

After obtaining permission from the original authors (Guven et al.), we translated a pre-existing questionnaire into Arabic [4]. Our institution's translation committee carefully supervised the translation process in collaboration with an epidemiology and emergency medicine expert. Subsequently, researchers conducted structured interviews with participants at the ED, offering the option of Arabic or English based on their language preference. The questionnaire contained three distinct sections: the first section was intended for securing informed consent; the second section included demographic information (gender, age, educational level, occupation, marital status, and nationality); the third section included six multiple-choice questions to assess the preferences of both patients and their family members regarding the reception of distressing news in the ED (Table 2). On average, the interview sessions lasted approximately 20 minutes.

### *Statistical analysis*

Data were entered using Microsoft Excel 2019, and subsequent analysis were performed using SPSS version 22 (Statistical Package for Social Sciences, IBM Corp., Armonk, New York, USA). Descriptive data were expressed as mean+/- standard deviation (SD) (min-max), whereas categorical data were expressed as frequencies (*n*) and percentages (%). The Pearson chi-square test was employed to evaluate significant differences between various groups. Additionally, the Mann–Whitney test was applied for data that did not exhibit a normal distribution,

such as age. Statistical significance was defined as a *p*-value less than 0.05.

## Results

Table 1 displays the participants' demographic characteristics. The overall average age was 37.23 years, ranging from 18 to 77 years. Most of the patients were: aged 31–50 years ($n$ = 132, 43.2%), male ($n$ = 184, 60.5%), Saudi ($n$ = 218, 71.7%), married ($n$ = 178, 58.6%), from the non-medical field ($n$ = 270, 88.8%), and had high education level ($n$ = 168, 55.3%).

Table 2 presents the responses of all participants to the interview-based questionnaire. Regarding preferences for doctor-patient communication, most participants (166 individuals; 54.6%) favored a formal and gentle approach. Regarding how a doctor should convey potentially negative news to a patient, most respondents (167; 54.9%) expressed a preference for "explaining the condition of the disease and how it developed." Regarding informing the patient's relatives about their death, most participants (154; 50.7%) believed this should be done "by keeping the values of faith in the foreground." Regarding who should be informed about the patient's death, a significant portion of the participants (205; 67.4%) believed that this information should be conveyed to "one of the family members." Regarding the location for delivering the news of a patient's death, most respondents (193; 63.5%) indicated a preference for "in a separate room where no other patients are present, sitting down face to face with the patient's relatives." Last, regarding where the patient's relatives should be during resuscitation efforts in the CPR room, most participants (156; 51.3%) suggested that they should "wait in a seat close to the room where CPR is performed."

Table 3 provides a comprehensive overview of questionnaire responses, including frequency rates, and highlights the level of significance of participants' responses based on their gender and education level. Statistically significant differences were observed between individuals with low and high education levels concerning their responses to the second ($p$ = 0.021) and fourth ($p$ = 0.040) items. Similarly, there were statistically significant variations between male and female participants regarding their responses to the first ($p$ = 0.010) and fourth ($p$ = 0.001) items.

***Table 1.*** *Demographic characteristics of participants (n = 304).*

| Characteristics | All participants ($n$ = 304) |
|---|---|
| Age (years) | 37.23 ± 13.25 (18.00–77.00) |
| Age groups | |
| 18–30 years | 120 (39.5%) |
| 31–50 years | 132 (43.2%) |
| 51–65 years | 43 (14.1%) |
| >65 years | 9 (3.0%) |
| Gender | |
| Male | 184 (60.5%) |
| Female | 120 (39.5%) |
| Nationality | |
| Saudi | 218 (71.7%) |
| Non-Saudi | 86 (28.3%) |
| Social status | |
| Single | 115 (37.8%) |
| Married | 78 (58.6%) |
| Divorced | 7 (2.3%) |
| Widow | 4 (1.3%) |
| Occupations | |
| Non-medical field | 270 (88.8%) |
| Medical field | 34 (11.2%) |
| Education levels | |
| Low (higher school and below) | 136 (44.7%) |
| High (University and above) | 168 (55.3%) |

## Discussion

This study examined the preferences of patients and their families regarding the delivery of bad news in the ED and assessed the impact of sociodemographic factors on these preferences. Recognizing the crucial role of effectively delivering bad news, emergency physicians are prompted to refine communication skills, prioritizing the needs of patients and their families to ensure the compassionate delivery of distressing information [4,15,16]. By aligning with patient preferences, physicians can enhance sensitivity and support during challenging times, emphasizing the importance of a tailored approach [17]. For example, many protocols such as the SPIKES, GRIEV_ING model, and BREAKS model, as well as newer approaches such as the ABCDE model, were established to systematize and improve communication skills for delivering bad news [12,18-20]. However, these models, primarily rooted in internal medicine, oncology, and anesthesiology, may not fully account for the unique challenges faced by emergency physicians, who often encounter families without extensive background information [1,21]. Furthermore, these protocols might not consider gender and educational and cultural backgrounds, which may influence communication effectiveness [4].

Regarding the first item, most participants preferred a formal and gentle communication style when receiving bad news. These results align with a Turkish study, in which most participants also favored this approach [4]. Interestingly, educational status did not significantly influence the participants' preferences. However, regarding gender, female participants preferred to communicate with doctors more formally and gently than male participants. It can be assumed that gender differences in preferred communication styles may be owing to the fact that female patients often seek more emotional support and rapport-building, leading to the preference for a formal and gentle approach from doctors in the ED; however, male patients may have different preferences. Regarding the second item, most patients preferred receiving distressing news with comprehensive medical details, including an explanation of the nature and development of the disease. This finding coincides with results from a Turkish study [4]. Furthermore, a

***Table 2.*** *Form study entitled "The preferences of patients about BBN Who admitted to the ED."*

| Items | All participants ($n$ = 304) |
|---|---|
| Q1. How do you want your doctor to communicate with you? | |
| Sincerely as my relative | 99 (32.6%) |
| Formally and gently | 166 (54.6%) |
| It does not matter | 39 (12.9%) |
| Q2. How should a doctor tell a possible negative situation to his/her patient? | |
| Directly | 45 (14.8%) |
| By keeping the values of faith in the foreground | 83 (27.3%) |
| By explaining the condition of the disease and how this was developed | 167 (54.9%) |
| It does not matter | 9 (3.0%) |
| Q3. How should a doctor tell the death of the patient to his/her family members? | |
| Directly | 43 (14.1%) |
| By keeping the values of faith in the foreground | 154 (50.7%) |
| By explaining the cause of death with medical details | 93 (30.6%) |
| It does not matter | 14 (4.6%) |
| Q4. To whom should a doctor tell the death of the patient? | |
| To one of the family members | 205 (67.4%) |
| To one of the relatives | 29 (9.5%) |
| To all family members to be present | 61 (20.1%) |
| It does not matter | 9 (3.0%) |
| Q5. Where should a doctor tell the death of the patient? | |
| In front of the reanimation room, by standing | 37 (12.2%) |
| In any part (room) of the ED | 46 (15.1%) |
| In a separate room where no other patients are present, by sitting down face-to-face with family members | 193 (63.5%) |
| It does not matter | 28 (9.2%) |
| Q6. Where should the family members be while the doctor is performing resuscitation to the patient in the CPR room? | |
| In the resuscitation room | 73 (24.0%) |
| By waiting in front of the CPR room | 58 (19.1%) |
| By waiting in a seat close to the room where CPR is performed | 156 (51.3%) |
| It does not matter | 17 (5.6%) |

statistically significant distinction emerged between patients with varying education levels in their responses to the second item. This outcome aligns with previous studies, indicating that individuals with higher educational backgrounds possess the ability to comprehend and seek disease-related information [4,14,22]. However, on examining gender differences, there were no statistical differences regarding responses to this item. Concerning the third item, there was a notable preference among patients and family members for doctors to emphasize faith-based values when delivering news of a patient's death. This inclination mirrors findings from a prior study [4]. Remarkably, there were no significant differences between participants with high and low educational backgrounds or gender distinctions in responses to the third item. Our outcomes are consistent with the aforementioned Turkish study, suggesting cultural and religious similarity as the likely reason for the congruence of results across the first three items [4].

Furthermore, regarding the fourth item, a striking majority strongly preferred involving only one of their family members in the BBN process during their final moments. In the Turkish study as well, most patients preferred expressing bad news to one family member only [4]. However, patients' viewpoints varied in other studies conducted in India, Japan, and Australia, which revealed a predominant preference for delivering difficult news to all family members [14,23,24]. This divergence may be attributed to the impact of different cultural backgrounds. Interestingly, our results revealed a statistically significant disparity as male participants favored BBN exclusively for a single family member, unlike their female counterparts. This suggests that female patients find solace in the presence of multiple family members when receiving distressing news. However, no statistically significant difference was identified regarding the fourth item based on participants' education level.

Our study revealed a compelling trend among family members regarding the fifth item, with a significant majority expressing a clear preference for receiving news of their loved one's passing in a private setting, away from the presence of other patients. Our findings resonate with two studies conducted in Iran and Turkey,

***Table 3.*** *Form study entitled "The Preferences of patients about BBN who admitted to the ED based upon education levels and gender."*

| Items | Education levels | | Significance | Gender | | Significance |
|---|---|---|---|---|---|---|
| | Low ($n$ = 136) | High ($n$ = 168) | | Male ($n$ = 184) | Female ($n$ = 120) | |
| 1st item | | | | | | |
| Sincerely as my relative | 47 (34.6%) | 52 (31.0%) | 0.757 | 72 (39.1%) | 27 (22.5%) | **0.010** |
| Formally and gently | 73 (53.7%) | 93 (55.4%) | | 90 (48.9%) | 76 (63.3%) | |
| It does not matter | 16 (11.8%) | 23 (13.7%) | | 22 (12.0%) | 17 (14.2%) | |
| 2nd item | | | | | | |
| Directly | 27 (19.9%) | 18 (10.7%) | **0.021** | 33 (17.9%) | 12 (10.0%) | 0.148 |
| By keeping the values of faith in the foreground | 43 (31.6%) | 40 (23.8%) | | 46 (25.0%) | 37 (30.8%) | |
| By explaining the condition of the disease and how this was developed | 63 (46.3%) | 104 (61.9%) | | 98 (53.3%) | 69 (57.5%) | |
| It does not matter | 3 (2.2%) | 6 (3.6%) | | 7 (3.8%) | 2 (1.7%) | |
| 3rd item | | | | | | |
| Directly | 25 (18.4%) | 18 (10.7%) | 0.089 | 31 (16.8%) | 12 (10.0%) | 0.384 |
| By keeping the values of faith in the foreground | 69 (50.7%) | 85 (50.6%) | | 89 (48.4%) | 65 (54.2%) | |
| By explaining the cause of death with medical details | 34 (25.0%) | 59 (35.1%) | | 55 (29.9%) | 38 (31.7%) | |
| It does not matter | 8 (5.9%) | 6 (3.6%) | | 9 (4.9%) | 5 (4.2%) | |
| 4th item | | | | | | |
| To one of the family members | 82 (60.3%) | 123 (73.2%) | 0.095 | 140 (76.1%) | 65 (54.2%) | **0.001** |
| To one of the relatives | 14 (10.3%) | 15 (8.9%) | | 10 (5.4%) | 19 (15.8%) | |
| To all family members to be present | 35 (25.7%) | 26 (15.5%) | | 30 (16.3%) | 31 (25.8%) | |
| It does not matter | 5 (3.7%) | 4 (2.4%) | | 4 (2.2%) | 5 (4.2%) | |
| 5th item | | | | | | |
| In front of the reanimation room, by standing | 18 (13.2%) | 19 (11.3%) | **0.040** | 23 (12.5%) | 14 (11.7%) | 0.373 |
| In any part (room) of the ED | 27 (19.9%) | 19 (11.3%) | | 31 (16.8%) | 15 (12.5%) | |
| In a separate room where no other patients are present, by sitting down face-to-face with family members | 75 (55.1%) | 118 (70.2%) | | 113 (61.4%) | 80 (66.7%) | |
| It does not matter | 16 (11.8%) | 12 (7.1%) | | 17 (9.2%) | 11 (9.2%) | |
| 6th item | | | | | | |
| In the resuscitation room | 28 (20.6%) | 45 (26.8%) | 0.259 | 46 (25.0%) | 27 (22.5%) | 0.877 |
| By waiting in front of the CPR room | 27 (19.9%) | 31 (18.5%) | | 36 (19.6%) | 22 (18.3%) | |
| By waiting in a seat close to the room where CPR is performed | 70 (51.5%) | 86 (51.2%) | | 91 (49.5%) | 65 (54.2%) | |
| It does not matter | 11 (8.1%) | 6 (3.6%) | | 11 (6.0%) | 6 (5.0%) | |

(*): a significance $p$-value.

which reported a similar inclination among patients. This further emphasizes the importance of providing transparent and comprehensive information to support families during emotionally challenging times. The convergence of results from multiple sources reinforces the significance of these preferences, emphasizing the ethical obligation to respect and address the emotional needs of families during these trying times. In the previous studies, most patients expressed disinterest in receiving bad news in public spaces such as hospital and ED corridors, where the presence of other patients could compromise privacy and sensitivity [3,4]. An intimate approach, involving sitting down for an in-person conversation, facilitates more personal and empathetic interaction during such sensitive moments. Furthermore, family members with a high educational level strongly preferred to receive the news in a private setting. This result is consistent with s study from India [14]. There were no significant differences between male and female participants regarding this item. We assume that the difference in preferences for receiving bad news between patients with low and high education levels may stem from varying levels of health literacy, empowerment, and desire for privacy. Highly educated patients, possibly equipped with greater health literacy and autonomy, may prioritize receiving sensitive information in a private setting to facilitate deeper understanding and decision-making, whereas patients with a low education level may be more accustomed to relying on healthcare providers for guidance and thus feel more comfortable receiving such information in a less private setting.

Last, for the sixth item, participants preferred not to remain in the room while CPR was performed, opting to wait in a seat near the patient's room. This is consistent with findings from the Turkish study [4]. Interestingly, the literature presents varying conclusions regarding this issue; some studies suggested that the presence of family members during CPR may aid in the grieving process [25-27]. Remarkably, when considering educational disparities and gender distinctions, the results yielded no statistically significant differences.

The present findings have significant practical implications in the ED. Healthcare professionals should recognize and respect the individual preferences of patients and their families when delivering bad news. Tailoring communication strategies based on factors such as gender and educational level is important to promote patient-centered care and ensure effective communication. Creating a supportive environment, including opportunities for private discussions and emotional support, is essential for optimizing the delivery of bad news in the ED setting. By integrating these recommendations into clinical practice, emergency physicians can improve patient outcomes and enhance the overall quality of care.

## Limitations

This study has some limitations. First, patient selection was restricted to a single medical center. This may limit the scope and applicability of the findings to diverse healthcare settings. Additionally, this study did not address ethnic differences between patients, warranting additional research including diverse cultural backgrounds and preferences for receiving bad news from emergency physicians.

## Conclusion

This study sought to analyze patients' and their families' preferences for the delivery of bad news in the ED, and to assess how socioeconomic variables influence these decisions. The most preferred approach for BBN to family members was sitting down face-to-face in a private room. Furthermore, patients typically wanted to obtain comprehensive details of their medical situation, and family members generally decided to remain nearby during the CPR procedure. Based on these results, it is advisable that EDs improve the understanding among ED physicians regarding patient preferences for receiving bad news by incorporating supplementary training sessions and workshops. These educational efforts should highlight the significance of adjusting communication approaches to accommodate patients' needs, considering factors such as their gender and education level.

**Acknowledgment**
The authors extend their deepest gratitude to the patients who participated in this study, providing invaluable insights on how bad news should be delivered in the emergency department.

**List of Abbreviations**

BBN Breaking bad news
CPR Cardiopulmonary resuscitation
ED Emergency department

**Conflict of interests**
The authors affirm that there is no conflict of interest with this article's publishing.

**Funding**
None.

**Consent to participate**
Written informed consent was acquired from each individual involved.

**Ethical approval**
The ethics committee of King Abdulaziz University, Jeddah, Saudi Arabia (ref:235-23) approved this study.

**Author details**
Imad Khojah[1,2], Marshad A. Almutairi[2], Fatmah Alsomali[1,2], Essam W. Zarei[2], Ahmed H. Khan[2], Amjad S. Alshardy[2], Abdulaziz K. Alghamdi[2], Mohammed A. Alghamdi[2]

1. Emergency Medicine Department, King Abdulaziz University Hospital, Jeddah, Saudi Arabia
2. Faculty of Medicine, King Abdulaziz University, Jeddah, Saudi Arabia

**References**

1. Park I, Gupta A, Mandani K, Haubner L, Peckler B. Breaking bad news education for emergency medicine residents: a novel training module using simulation with the SPIKES protocol. J Emerg Trauma Shock. 2010 Oct;3(4):385–8. https://doi.org/10.4103/0974-2700.70760
2. Buckman R. Breaking bad news: why is it still so difficult?. Br Med J (Clin Res Ed). 1984 May;288(6430):1597–9. https://doi.org/10.1136/bmj.288.6430.1597
3. Aminiahidashti H, Mousavi SJ, Darzi MM. Patients' attitude toward breaking bad news; a brief report. Emerg (Tehran, Iran). 2016;4(1):34–7.
4. Guven R, Kuday Kaykisiz E, Onturk H, Sasmaz MI, Ari A, Eyupoglu G, et al. Breaking bad news in the emergency department: how do the patients want it? Eurasian J Emerg Med. 2018;17(3):97–102. https://doi.org/10.5152/eajem.2018.27146
5. Biazar G, Delpasand K, Farzi F, Sedighinejad A, Mirmansouri A, Atrkarroushan Z. Breaking bad news: a valid concern among clinicians. Iran J Psychiatry. 2019 Jul;14(3):198–202. https://doi.org/10.18502/ijps.v14i3.1321
6. Seifart C, Hofmann M, Bär T, Riera Knorrenschild J, Seifart U, Rief W. Breaking bad news-what patients want and what they get: evaluating the SPIKES protocol in Germany. Ann Oncol Off J Eur Soc Med Oncol. 2014 Mar;25(3):707–11. https://doi.org/10.1093/annonc/mdt582
7. Arbabi M, Rozdar A, Taher M, Shirzad M, Arjmand M, Ansari S, et al. Patients' preference to hear cancer diagnosis. J Psychiatry. 2014;9:8–13.
8. Rosenzweig MQ. Breaking bad news: a guide for effective and empathetic communication. Nurse Pract. 2012 Feb 2;37(2):1. https://doi.org/10.1097/01.NPR.0000408626.24599.9e
9. Toutin-Dias G, Daglius-Dias R, Scalabrini-Neto A. Breaking bad news in the emergency department: a comparative analysis among residents, patients and family members' perceptions. Eur J Emerg Med. 2018 Feb;25(1):71–6. https://doi.org/10.1097/MEJ.0000000000000404

10. Dosanjh S, Barnes J, Bhandari M. Barriers to breaking bad news among medical and surgical residents. Med Educ. 2001 Mar;35(3):197–205. https://doi.org/10.1046/j.1365-2923.2001.00766.x
11. Gonçalves F, Marques A, Rocha S, Leitão P, Mesquita T, Moutinho S. Breaking bad news: experiences and preferences of advanced cancer patients at a Portuguese oncology centre. Palliat Med. 2005 Oct;19(7):526–31. https://doi.org/10.1191/0269216305pm1070oa
12. Martis L, Westhues A. A Synthesis of the literature on breaking bad news or truth telling: potential for research in India. Indian J Palliat Care. 2013 Jan;19(1):2. https://doi.org/10.4103/0973-1075.110215
13. Tse CY, Chong A, Fok SY. Breaking bad news: a Chinese perspective. Palliat Med. 2003 Jun;17(4):339–43. https://doi.org/10.1191/0269216303pm751oa
14. Rao A, Ekstrand M, Heylen E, Raju G, Shet A, Shet A. Breaking bad news: patient preferences and the role of family members when delivering a cancer diagnosis. Asian Pac J Cancer Prev. 2016;17(4):1779–84. https://doi.org/10.7314/APJCP.2016.17.4.1779
15. Tuckett AG. Truth-telling in clinical practice and the arguments for and against: a review of the literature. Nurs Ethics. 2004 Sep;11(5):500–13. https://doi.org/10.1191/0969733004ne728oa
16. Abbaszadeh A, Ehsani SR, Begjani J, Kaji MA, Dopolani FN, Nejati A, et al. Nurses' perspectives on breaking bad news to patients and their families: a qualitative content analysis. J Med Ethics Hist Med. 2014 Nov 12;7:18.
17. Kwame A, Petrucka PM. A literature-based study of patient-centered care and communication in nurse-patient interactions: barriers, facilitators, and the way forward. BMC Nurs. 2021 Sep;20(1):158. https://doi.org/10.1186/s12912-021-00684-2
18. Hobgood C, Harward D, Newton K, Davis W. The educational intervention "GRIEV_ING" improves the death notification skills of residents. Acad Emerg Med. 2005 Apr;12(4):296–301. https://doi.org/10.1111/j.1553-2712.2005.tb01943.x
19. Rabow MW, McPhee SJ. Beyond breaking bad news: how to help patients who suffer. West J Med. 1999 Oct;171(4):260–3.
20. Narayanan V, Bista B, Koshy C. 'BREAKS' protocol for breaking bad news. Indian J Palliat Care. 2010 May;16(2):61. https://doi.org/10.4103/0973-1075.68401
21. Williams AG, O'Brien DL, Laughton KJ, Jelinek GA. Improving services to bereaved relatives in the emergency department: making healthcare more human. Med J Aust. 2000 Nov;173(9):480–3. https://doi.org/10.5694/j.1326-5377.2000.tb139300.x
22. Parker PA, Baile WF, de Moor C, Lenzi R, Kudelka AP, Cohen L. Breaking bad news about cancer: patients' preferences for communication. J Clin Oncol. 2001 Apr;19(7):2049–56. https://doi.org/10.1200/JCO.2001.19.7.2049
23. Fujimori M, Akechi T, Morita T, Inagaki M, Akizuki N, Sakano Y, et al. Preferences of cancer patients regarding the disclosure of bad news. Psychooncology. 2007 Jun;16(6):573–81. https://doi.org/10.1002/pon.1093
24. Butow PN, Kazemi JN, Beeney LJ, Griffin AM, Dunn SM, Tattersall MH. When the diagnosis is cancer: patient communication experiences and preferences. Cancer. 1996 Jun;77(12):2630–7. https://doi.org/10.1002/(SICI)1097-0142(19960615)77:12<2630::AID-CNCR29>3.3.CO;2-K
25. Tsai E. Should family members be present during cardiopulmonary Resuscitation?. N Engl J Med. 2002 Mar 28;346(13):1019–21. https://doi.org/10.1056/NEJM200203283461312
26. McClenathan BM, Torrington KG, Uyehara CF. Family member presence during cardiopulmonary resuscitation: a survey of US and international critical care professionals. Chest. 2002 Dec;122(6):2204–11. https://doi.org/10.1378/chest.122.6.2204
27. Jabre P, Belpomme V, Azoulay E, Jacob L, Bertrand L, Lapostolle F, et al. Family presence during cardiopulmonary resuscitation. N Engl J Med. 2013 Mar;368(11):1008–18. https://doi.org/10.1056/NEJMoa1203366