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EXPLORING HEALTH PROFESSIONALS' APPROACHES TO BREAKING BAD NEWS IN THE EASTERN MEDITERRANEAN REGION

BY

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ABSTRACT

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Title: Exploring health professionals' approaches to breaking bad news in the Eastern Mediterranean Region

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Breaking bad news is challenging, requiring effective communication skills, empathy, and cultural sensitivity. The research was conducted in two phases, the first a scoping review of health professionals' views and experiences of breaking bad news in the World Health Organization Eastern Mediterranean region. Of the 24 studies, key themes were: positive views and experiences (e.g., perceived adequate knowledge/skills); negative views and experiences (e.g., reported lack of training); practice varies with experience; and need for education/training. The second study was qualitative, exploring experiences of resident doctors at Hamad Medical Corporation, Qatar 3-months post-participation in breaking bad news workshop. In addition to themes similar to those of the scoping review, three were mapped to the Context, Input, Process, Product (CIPP) model: training needs assessment; positive workshop experiences; and lasting impact. In conclusion, the research has highlighted that challenges persist regarding breaking bad news and that further training is required and likely beneficial.

DEDICATION

"To my beloved wife, Mrs. Zelaikha Sultan Al Naama, this thesis is dedicated with the deepest gratitude and love. Your unwavering support, wisdom, and kindness have been the cornerstones of my journey. Throughout the challenges and triumphs of my career as a psychiatrist and in my recent role as an assistant director at the medical education department of Hamad Medical Corporation, you have been my constant source of strength and inspiration. As we celebrate two decades of our union, this accomplishment, my second master's degree, is as much yours as it is mine."

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CHAPTER 1: INTRODUCTION

This introductory chapter provides the reader with a synopsis of key issues relating to breaking bad news generally and specifically in relation to the World Health Organization (WHO) Eastern Mediterranean Region. It commences with an overview of communication and consultation skills in healthcare practice which are then considered in relation to breaking bad news. Definitions and impact of breaking bad news are described along with related protocols training and practice, with specific reference to the WHO Eastern Mediterranean Region. The chapter ends with statement of the overall aim of the research and structure of the thesis.

1.1 Communication skills among health professionals

In the healthcare field, successful communication is an absolute requirement at every stage of a clinical interview and its importance must not be underestimated (Ahmady et al., 2014). A conscious, informed effort to ensure that healthcare practice is underpinned by appropriate communication skills is fundamental and is the responsibility of all health professionals. A review by Epstein et al. published in 1993 suggested that over a 40-year career, a primary care physician is expected to conduct a minimum of two million patient interviews (Epstein et al., 1993). While this review is rather dated and focuses on only physicians and the primary care setting, it illustrates the frequency of patient consultations and hence underscores the importance of skilled communication. The cornerstone of effective communication lies in fostering mutual understanding and trust, as miscommunication between health professionals and patients is frequently linked to poorer clinical outcomes, low levels of patient satisfaction and malpractice claims (Tiwary et al., 2019). In all healthcare settings, patient-centered communication is regarded as a major contributor to optimal care provision (Soosaipillai et al., 2020). Several studies have linked physician-patient

communication to adherence to treatment (Chewning & Sleath, 1996; Osterberg & Blaschke, 2005). Indeed, patients and their families have identified optimal communication as one of the paramount elements in healthcare, particularly in situations involving end of life or when challenging news is delivered (Anderson et al., 2019). Several reviews have reported that when health professionals deliver such bad news competently, it can lead to outcomes such as higher patient engagement and increased overall satisfaction with their healthcare (Fallowfield & Jenkins, 2004; Luz et al., 2017). Where bad news is not delivered competently, it can result in poorer patient outcomes, greater patient dissatisfaction, loss of trust in the caregiver, misunderstandings regarding diagnoses and care, anxiety, stress, and even litigation, as described later in this chapter.

1.2 Definition of bad news

In simple terms, bad news is that which can adversely affect how recipients view their future. According to Buckman, one of the leading scholars in this field, bad news is defined as "any information likely to alter drastically a patient's view of his or her future" (Buckman, 1984). In a narrative literature review, Ptacek and Eberhardt described bad news as pertaining to a situation where there is no hope and risks upsetting an established lifestyle (Ptacek & Eberhardt, 1996). Recognizing that interpretation of what may be considered neutral, good or bad is subjective, Ptacek and Eberhardt further proposed that "news is bad to the extent that it results in a cognitive, behavioral, or emotional deficit in the person receiving the news that persists for some time after the news is received" (Ptacek & Eberhardt, 1996). This interpretation is shaped by an individual's life experiences, personality, spiritual beliefs, philosophical stance, perceived social support, and emotional resilience. Despite such gradations of bad news, some instances are universally considered to be distressing. For example,

informing a mother that her baby is stillborn is universally perceived to be bad news. However, in other instances, the interpretation of news as bad varies between individuals. Examples include explaining the necessity of a hip replacement that prevents a woman from traveling to witness the birth of her first grandchild and informing a window cleaner with limited options for other employment about the implications of a diagnosis of epilepsy. Although these situations may not be perceived as equally devastating by impartial observers, these situations can have far-reaching consequences beyond the immediate health aspect, affecting patients and their families in various distressing ways (Fallowfield & Jenkins, 2004).

1.3 Impact of bad news on individuals

Health professionals are responsible for breaking bad news to patients and their families, with most likely to be required to carry out this task at some point in their practice. Several studies have shown that bad news can have significant negative consequences for patients and families. Communication of bad news can imply hopelessness and negative patient outcomes (Almansour & Abdel Razeq, 2021; Beyraghi et al., 2011). Furthermore, the manner in which health professionals break bad news can further aggravate the emotional insult (Anderson, 2019), and may influence patients' perceptions of their disease which can lead to either treatment cessation or continuation (Kaplan & Price, 2020). It is therefore unsurprising that breaking bad news has emerged as a key component in the repertoire of healthcare communication skills (Atienza-Carrasco et al., 2018; Warnock et al., 2017).

Similarly, conveying bad news is also a daunting task for health professionals, and is associated with potential multifaceted psychological consequences. It has been reported that following breaking bad news health professionals worry about patients losing hope for successful treatment outcomes (Beyraghi et al., 2011). A meta-synthesis

of 11 qualitative studies that explored experiences of breaking bad news by health professionals reported four major themes: (i) health professionals had difficulty in handling their own emotional and physical responses; (ii) relational distress, connected to attachment and identification with patients; (iii) the fear of getting the diagnosis wrong ultimately leading to self-blame; and (iv) a culture of invulnerability among practitioners with their own self-care deprioritized (Francis & Robertson, 2023). Regularly delivering bad news can lead to chronic emotional stress which over time can contribute to burnout characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment (de Freitas Domingues, 2016). A scoping review of 24 studies assessed health professionals' compassion fatigue reported that physicians are more likely to have compassion fatigue compared to nurse largely due to their primary responsibility of breaking bad news (Garnett et al., 2023).

Although breaking bad news poses a significant challenge to less experienced health professionals, these challenges have also been reported at more senior levels. For example, consultant oncologists also face difficulty in breaking bad news due to the greater burden of responsibility (Mirza et al., 2019). It is believed that senior oncologists break bad news on average 20,000 times during their careers (Paul et al., 2009). Less experienced health professionals have been reported as being unable to fully comprehend the concerns of patients who are diagnosed with cancer (Maguire et al., 1996). For such patients, feelings of mistrust, anger, and fear can arise following poor delivery of bad news. There are several other factors that can exacerbate psychological consequences for health professionals. The task of breaking bad news weighs heavily when there is a long-standing relationship with the patient or a prior successful outcome has been conveyed (Back et al., 2005).

The level of health professionals' communication skills is largely dependent on

completion of formal training (Oikonomidou et al., 2017). There is evidence that those who do not undertake formal training in breaking bad news are more likely to feel ill-prepared for this task (Narayanan et al., 2010). While less emphasis has generally been placed on training for health professionals in breaking bad news, reports of formal training for health professionals in the delivery of bad news at undergraduate and graduate levels are emerging, including traditional and virtual reality training approaches (Ochs et al., 2019).

1.4 Protocols for breaking bad news

Recognizing the importance of breaking bad news, several validated protocols have been developed, with the most commonly cited being the SPIKES protocol (Setting up, Perception, Invitation, Knowledge, Emotions with Empathy, and Strategy or Summary) and the ABCDE model (Advanced preparation, Building therapeutic relationship, Communicating effectively, Dealing with reactions, and Encouraging emotions) (Monden et al., 2016). SPIKES is a six-step protocol proposed by Baile et al. to enable health professionals to disclose unfavorable prognoses (Baile et al., 2000). The aim of the SPIKES protocol is to empower health professionals in achieving the following four crucial objectives in breaking bad news: (i) acquiring relevant information from the patient; (ii) effectively communicating medical details; (iii) offering support; and (iv), engaging the patient in collaboratively developing a strategy or treatment plan for the future (Baile et al., 2000). Rabow and McPhee proposed the ABCDE model to guide health professional in breaking bad news (Rabow & McPhee, 1999). The first aspect, ‘advanced preparation’ relates to preparations prior to breaking bad news. These preparations include arranging for adequate time for discussion with the patients, reviewing clinical information of the patients, avoiding interruptions, and rehearsing mentally. The second aspect focuses on building a therapeutic environment

by determining what and how much patient is willing to know about bad news. The ABCDE protocol also places emphasis on effective communication, adopting a frank and compassionate communication style, dealing with reactions, and avoiding any criticism of colleagues. The final aspect of the ABCDE protocol encourages emotion, offering realistic hope to patient and their families (Rabow & McPhee, 1999).

While healthcare education historically focused on providing clinical skills, focusing less on social skills such as communication, most medical schools across the world have now integrated communication skills into their curriculum (Gebhardt et al., 2021). For example, graduates in the United States are required to demonstrate competence on communicative clinical skills for medical licensing (Scoles et al., 2003). Developments in educational programs are replicated in many countries and health professions (Servotte et al., 2019). Despite this progress, there is still a gap in relation to training in breaking bad news, with evidence that graduates from health programs, for the most part, do not perceive themselves equipped to break bad news. Indeed, recent studies have highlighted that health professionals identified breaking bad news as a critical part of their responsibilities and expressed the need for additional training (Ferraz Gonçalves et al., 2017; Yi et al., 2022).

1.5 Recent systematic or scoping reviews relating to breaking bad news

Several recent systematic reviews or scoping reviews have been published regarding breaking bad news experiences. A systematic review by Bousquet et al. assessed the perspective of oncologists in breaking bad news to the patients. Synthesis of data from 40 articles and more than 600 oncologists identified that a number of external factors impact the breaking bad news process including family members' involvement, cultural factors, and various institutional factors (Bousquet et al., 2015). The systematic review by Sharif et al. assessed current trends and research themes in

35 articles on breaking bad news. Three major themes identified were initiative for improving breaking bad news, different methods of delivering bad news, and emotional aspects of breaking bad news (Sharif et al., 2023). Mahendiran et al., conducted a systematic review of 37 studies which reported the effectiveness of the application of the SPIKES protocol in breaking bad news. The key finding was that application of the SPIKES protocol was linked with better performance, knowledge, and leaner's satisfaction (Mahendiran et al., 2023). A systematic review of 40 studies also published in 2023 reported that breaking bad news is a recipient-centered process, with respect, support, and empathy being the key features of this process (Jalali et al., 2023). The association between breaking bad news and oncologist burnout was highlighted in a scoping review published in 2017, in which the authors also recognized the potential of effective communication in minimizing this burden (Chow & DBioethics, 2017). A systematic review of 17 studies also explored the impact of breaking bad news training related interventions findings that interventions were associated with significant improvements in observer-rated news delivery skills and moderate improvements in physician confidence (Johnson & Panagioti, 2018b).

1.6 Breaking bad news; the Eastern Mediterranean Region

Rodriguez Del Pozo et al. noted that while the phenomenon of breaking bad news is relatively well-understood throughout the western world, it has not penetrated to the same extent elsewhere (Rodriguez Del Pozo et al., 2012). Given the differences in culture and religion in different parts of the world, it is likely that the ways in which bad news is delivered and received may differ, as will the potential consequences of the delivery. For example, western countries are characterized by secularism, individualism, respect for patient autonomy, full diagnosis disclosure, and litigiousness, all of which may impact breaking bad news (Zhang et al., 2021).

The World Health Organization (WHO) Eastern Mediterranean region comprises 21 member states, with a population of nearly 679 million (WHO, 2023). This region has a diverse and culturally rich landscape, presenting a distinctive blend of cultural, religious and linguistic diversity, potentially shaping healthcare providers' approaches to delivering sensitive information (Khalil, 2013). In this region, religious and paternalistic cultural values guide behavior and decision-making, which may include how bad news is delivered and perceived (Arbabi et al., 2010; Mostafavian & Shaye, 2018).

The only relevant review to date which targeted Middle Eastern countries was a narrative review by Khalil published in 2013 of patients, family members, health professionals and/or caregivers regarding truth disclosure about a cancer diagnosis. In this very specific review, 55 studies were identified but limited details were provided of specific participants, methods and findings (Khalil, 2013). Given the developments in the practices of breaking bad news, there is need for an updated review which explores the phenomenon of breaking bad news more generally.

1.7 Research aim and thesis structure

The overall aim of this research was to explore health professionals' approaches to breaking bad news in the WHO Eastern Mediterranean Region.

The thesis is presented as two interlinked studies:

1. The first is a scoping review of the peer-reviewed literature on health professionals' views and experiences of breaking bad news in the WHO Eastern Mediterranean region.

2. The second was a qualitative study that aimed to explore the related experiences of resident doctors 3-months after participating in a breaking bad news workshop.

Full details of the aim, methods, results, discussion, and conclusion of each of these studies are provided in chapters 2 and 3. The final chapter provides a brief overall discussion, with consideration of the potential impact of the research.

CHAPTER 2: SCOPING REVIEW

2.1 Introduction to scoping reviews

In recent years, scoping reviews have gained significant popularity for mapping research evidence on a topic. Scoping reviews are designed to address questions that are frequently exploratory (Daudt et al., 2013). They encompass various literature types and adopt a broad approach to mapping the existing body of literature. Furthermore, a scoping review can be adopted when the topic has not been extensively reviewed. Scoping reviews are generally conducted to assess the nature of research activity on a topic.

Scoping reviews share a lot of similarities with systematic review, with both using transparent methods to identify relevant literature on the topic (DiCenso et al., 2010). The main differences between systematic and scoping reviews stems from their distinct purposes and objectives. Firstly, a scoping review is designed to map the existing literature in a particular subject area, while a systematic review aims to consolidate the best available research evidence on a specific question (Arksey & O'Malley, 2005; Clarke, 2011). Consequently, a scoping review aims to present a comprehensive overview of a potentially vast and varied body of literature related to a broad topic, whereas a systematic review seeks to gather empirical evidence from a relatively smaller pool of studies addressing a focused research question (Arksey & O'Malley, 2005; Clarke, 2011). Secondly, scoping reviews typically include a broader array of study methodologies compared to systematic reviews which often concentrate on specific methodologies, e.g., randomized controlled trials when evaluating intervention efficacy. Thirdly, scoping reviews seek to offer a descriptive summary of the reviewed material without critically appraising individual studies or synthesizing evidence from different studies. In contrast, systematic reviews strive to provide a

synthesis of evidence from studies that have been assessed for the risk of bias (Brien et al., 2010; Higgins & Green, 2008).

For this phase of the research, the aims and objectives aligned to a scoping rather than systematic review, with no intention to critically appraise the studies or synthesize the evidence in relation to a specific review question. The focus was on describing the primary literature and identifying gaps for future research.

2.2 Aims and Objectives

The overall aim was to scope the peer-reviewed literature on health professionals' views and experiences of breaking bad news in the WHO Eastern Mediterranean region.

The specific review objectives were to:

1. Describe study aims, designs, methodologies, methods, underpinning theories, and populations.
2. Describe collated outcomes and key findings in relation to any positive and negative views and experiences.
3. Identify gaps in the literature for further study.

2.3 Methods

The scoping review was conducted in accordance with the Joanna Brigg Institute's (JBI) methodology for scoping reviews (Peters et al., 2020). The study inclusion process and the search results are reported according to the Preferred Reporting Items for Systematic Reviews and Meta-analyses extension for scoping review (PRISMA-ScR) (Moher et al., 2015).

2.3.1 Identifying the Research Questions

The review questions were framed as review aims and objectives, as stated earlier.

2.3.2 Identifying relevant studies

This step entailed identifying pertinent research by formulating a strategy detailing the inclusion and exclusion criteria, databases, search terms, and search years. The inclusion criteria were described in terms of the population, concept, and context (PCC) model.

2.3.2.1 Population

The participant criterion was being a health professional. All health professionals were included with no exclusions.

2.3.2.2 Concept

The concept criterion comprised "breaking bad news" as a phenomenon of interest, as defined and described in the papers.

2.3.2.3 Context

The geographic context for this study was the WHO Eastern Mediterranean Region. The countries in the WHO Eastern Mediterranean region are the Gulf Cooperation Council (GCC) members [Qatar, Saudi Arabia, Bahrain, Oman, Kuwait, and the United Arab Emirates], and Djibouti, Egypt, Iran, Iraq, Israel, Jordan, Libya, Lebanon, Morocco, Syria, Malta, Tunisia, West Bank and Gaza, and Yemen (WHO, 2023).

The search was conducted in the following databases: PubMed, Scopus, Embase, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Ebsco eBooks, and Education Resources Information Center (ERIC) via Embase. Medical Subject Headings (MeSH) and keywords were used for the search, with the main concepts being,

a. Breaking bad news
b. Health professionals

c. Eastern Mediterranean Region

The search strategy as applied to PubMed is presented in Table 1. The search was adapted to the other databases as given in Appendix A.

Table 1. Search strategy and search results for PubMed

Key variables	**Sub terms**	**Search options**	**Search Results (Date: 6 July 2023)**
1. Breaking bad news	1.1 Bad news	All fields	3288
2. Health Professional	2.1 Health personnel	All fields	605376
	2.2 Health professional*	TI OR AB	67882
	2.3 Healthcare professional*	TI OR AB	36437
	2.4 Doctor*	TI OR AB	150300
	2.5 Nurse*	TI OR AB	318999
	2.6 Radiologist*	TI OR AB	61518
	2.7 Pharmacist*	TI OR AB	42126
	2.8 Dentist*	TI OR AB	88829
	2.9 Physiotherapist*	TI OR AB	10554
	2.10 Dietitian*	TI OR AB	7765
	2.11 Psychologist*	TI OR AB	18794
	2.12 Laboratory technician*	TI OR AB	1581
	2.13 Physician*	TI OR AB	454263
	2.14 Allied health	TI OR AB	11936
	2.15 Speech therapist*	TI OR AB	1119
	2.16 Psychotherapist*	TI OR AB	3481
3. WHO Eastern Mediterranean Region	3.1 Middle East	Mesh (MH)	159818
	3.2 Middle East	All fields	228122
	3.3 Afghanistan	All fields	8923
	3.4 Bahrain	All fields	4269
	3.5 Djibouti	All fields	587
	3.6 Egypt	All fields	132038
	3.7 Iran	All fields	250507
	3.8 Iraq	All fields	21923
	3.9 Jordan	All fields	48438
	3.10 Kuwait	All fields	14038
	3.11 Lebanon	All fields	39948
	3.12 Libya	All fields	3564
	3.13 Morocco	All fields	21876
	3.14 Oman	All fields	13460
	3.15 Palestine	All fields	4697
	3.16 Qatar	All fields	19540
	3.17 Saudi Arabia	All fields	133544
	3.18 Somalia	All fields	3007
	3. 19 Sudan	All fields	15716
	3.20 Syria	All fields	6211
	3.21 Tunisia	All fields	30392
	3.22 United Arab Emirates	All fields	22051
	3.23 Yemen	All fields	4756
1.Overall	1+2+3		79

2.3.3 Study selection

Following the search, all identified citations were collated and uploaded into EndNote Web (Clarivate Analytics, PA, USA), with duplicates removed. Titles and abstracts were independently screened by two team members against the inclusion criteria. Potentially relevant sources were retrieved in full, and their citation details imported into Rayyan (Ouzzani et al., 2016). This free web tool is designed to help researchers conduct systematic reviews, scoping reviews, and other knowledge synthesis projects by dramatically speeding up the process of screening and selecting studies. The full text of citations chosen was independently assessed in detail against the inclusion by two team members, as per the screening of titles and abstracts. Reasons for exclusion were recorded and are reported in the scoping review. Any disagreements that arose between the reviewers at each stage of the selection process were resolved through discussion or with the input of an additional reviewer.

2.3.4 Charting the data

A data extraction tool was developed in Microsoft Excel to record the data extracted from each study. The tool was piloted, and minor modifications made before being used. Two independent reviewers extracted data from each study. The data extracted were: authors, year, title, journal, country, aim, design, participants, number (response rate), setting, method, theory used, data collection tool, key findings, the authors' stated study strengths and weaknesses, and conclusion. Any reviewer disagreements were resolved through discussion or with an additional reviewer.

2.3.5 Summarizing and reporting the results

The results of the review were summarized and are reported as aligned with the specific review objectives.

2.4 Results

2.4.1 Screening

Figure 1 provides the PRISMA flow chart for the scoping review. The search generated 4,883 records, reduced to 4,805 after the removal of duplicates, and were exported to Rayyan. Screening of titles and abstracts reduced the number to 64, two of which could not be retrieved. Full-text screening eliminated a further 38, leaving 24 studies to be

included in the review. The reasons for exclusion were primarily related to population, publication type, outcome, and design.

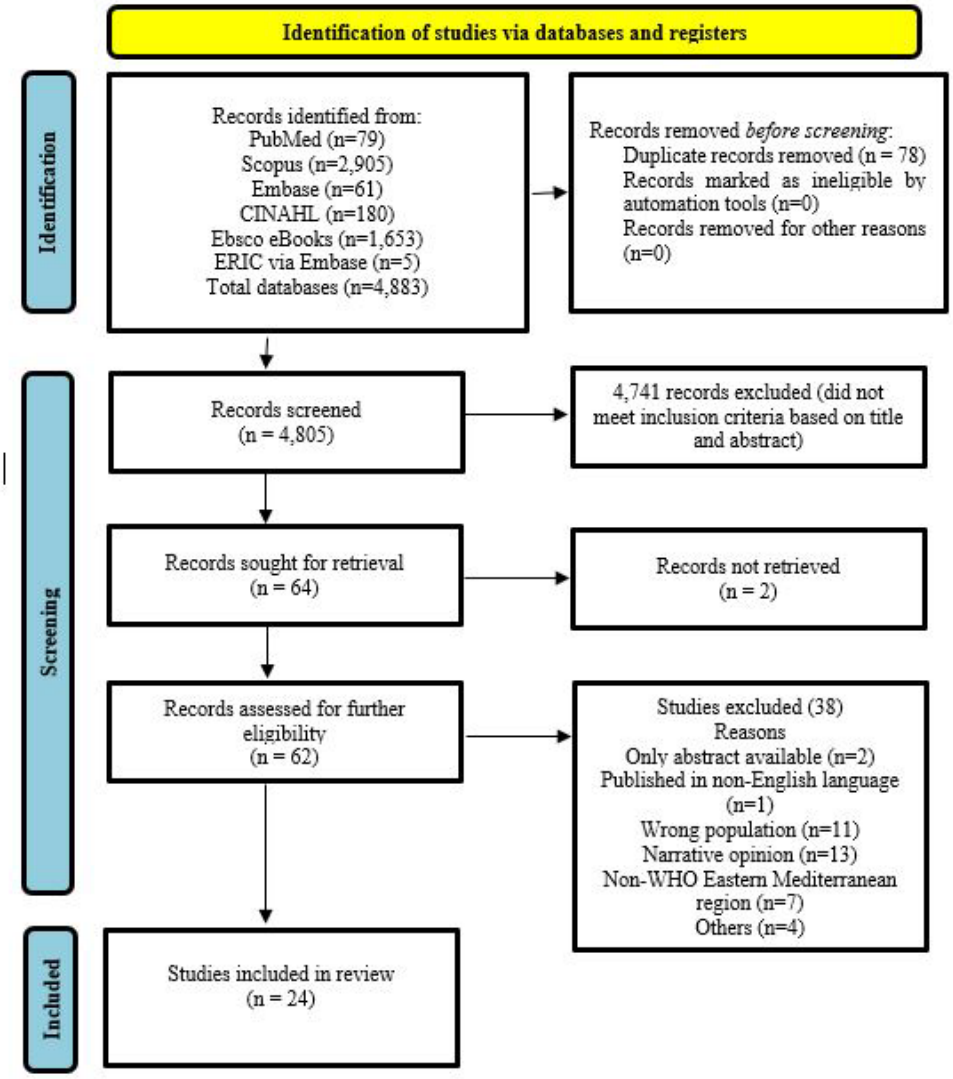

Figure 1: Scoping review PRISMA flow diagram

2.4.2 Study aims, designs, methodologies, and study populations

Table 2 gives the data extraction in terms of the aims, countries, designs, participants, setting, use of theory, and data collection tool development. All the studies were published from 2006 to 2022. Half of the studies were published in Iran (n=12). Two studies were published from each of Lebanon, Jordan, Egypt, and Sudan with one study from each of Saudi Arabia, Bahrain, and Turkey (one study did not specify the

region). Most studies utilized a cross-sectional study design (n=21), with one a non-randomized controlled study design, one a semi-experimental design and study, and one a virtual instructional design. Study participants encompassed various professional backgrounds, including physicians (15 studies), nurses (4), physicians and nurses (2), physicians and residents (2), and residents (1).

A total of 4,710 participants were included in the 24 studies, with the largest study reporting data from 500 participants (cross-sectional survey of physicians, response rate of 69%) and the smallest study included 12 participants. Cross-sectional survey studies reported response rates ranging from 30%-100%. Nine studies reported using the SPIKES protocol in questionnaire development, while another nine adopted questionnaires from previously published studies. In the remaining cross-sectional studies, little detail was provided on questionnaire development. No study reported the use of any theory in the development of data collection tools. Similarly, few studies provided details on questionnaire piloting prior to use. The study settings spanned private/public hospitals and medical centers, private/public, university hospitals, cancer centers, and intensive care departments.

Table 2. Data extraction of the included studies

Authors, year	Stated aim	Country	Design	Participants, n (response rate)	Setting	Theory	Data collection tool development
Amiel et al., 2006	Evaluate the reliability and validity of a competence-based assessment, utilizing simulated patients as evaluators, to assess primary care physician's ability to deliver bad news	N/A but all authors were from Israel, so it was assumed that it is from Israel	Non-randomized controlled study	34 general practitioners; 17 in the study group, 17 in the control	General practice	None	Based on 'How to Break Bad News' by Buckman. Trained simulated patients presented the scenarios in 8 stations who evaluated candidates utilizing global ratings of 2 Likert scale questionnaires.
Arbabi et al., 2010	Assessment of attitude towards breaking bad news to patients	Iran	Cross-sectional survey	50 physicians and 50 nurses	Cancer Institute	None	Questionnaire based on literature review. Focused on patients' and doctors' interviews, and the factors affecting how to disclose diagnosis and bad news. Content validity was assessed by 5 oncology and psychiatry professors. No detail was given about piloting.
Al-Mohaimeed et al., 2013	Explore the perspective and practices regarding breaking bad news to patients	Saudi Arabia	Cross-sectional survey	458 physicians (30%)	Public and private hospitals	None	Developed from SPIKES protocol. The questionnaire was validated by three experts in communication skills. No detail was given about piloting.

Authors, year	Stated aim	Country	Design	Participants, n (response rate)	Setting	Theory	Data collection tool development
Shomoossi et al., 2013	Investigate the delivery of death notifications by nurses	Iran	Cross-sectional survey	97 nurses (response rate not given)	Hospital	None	Questionnaire developed from the review of published literature and ABCDE strategies. Assessed test-retest and validity co-efficient. No detail was given about piloting.
Naji et al., 2014	Examine disclosure practices and factors affecting them	Lebanon	Cross-sectional survey	500 physicians (69%)	Hospital	None	Questionnaire based on previous study. No details of validity testing or piloting.
Farhat et al., 2015	Identify the attitudes regarding the disclosure of a cancer diagnosis	Lebanon	Cross-sectional survey	363 patients, families, friends, nurses, and physicians (94.5%). 13% of respondents were oncologists and other specialists	Hospital	None	Questionnaire based on previous study. No detail was given about further validity testing or piloting.
Imanipour et al., 2015	Determine the role, perspective, and knowledge regarding breaking bad news	Iran	Cross-sectional survey	160 nurses (response rate not given)	ICU	None	Questionnaire based on the SPIKES protocol. Content validity assessed by professors in medical ethics, psychiatry, and nursing. Pilot study conducted with test-retest reliability.
Ozyemisci-Taskiran et al., 2016	Explore experiences and	Turkey	Cross-sectional survey	69 physiatrists (response rate	Hospital	None	Questionnaire based on the SPIKES protocol, literature and interviews with

Authors, year	Stated aim	Country	Design	Participants, n (response rate)	Setting	Theory	Data collection tool development
	opinions about breaking bad news to patients with spinal cord injury			not given)			experts. No detail given about further validity testing or piloting.
Adeli et al., 2016	Examine the attitudes regarding revealing influential news to patients	Iran	Cross-sectional survey	150 physicians (100%)	Public, private sector or both	None	Questionnaire based on expert panel recommendations. Face validity by faculty members and internal reliability tested. No detail given about piloting.
Borgan et al., 2018	Assess the truth disclosure practices when encountering patients with serious illness	Jordan	Cross-sectional survey	240 physicians (60.8%)	4 Hospitals	None	Questionnaire based on previous study. No detail about validity testing. Piloted in 15 physicians.
Muneer et al., 2018	Assess the attitude and practice regarding breaking bad news	Sudan	Cross-sectional survey	291 physicians (54%)	Teaching hospital	None	Questionnaire based on previous study. No detail given about further validity testing or piloting.
Biazar et al., 2019	Investigate the way bad news is delivered	Iran	Cross-sectional survey	243 specialists and residents (97%)	Hospital	None	Questionnaire based on previous study. Tested for validity and reliability. No detail was given about piloting.
Mostafavian et al., 2018	Evaluate the ability and skills of physicians in delivering bad	Iran	Cross-sectional survey	70 physicians (response rate not given)	2 hospitals	None	Questionnaire based on SPIKES protocol. No detail given about piloting.

Authors, year	Stated aim	Country	Design	Participants, n (response rate)	Setting	Theory	Data collection tool development
	news to cancer patients						
Tehran et al., 2019	Evaluate the skill of general physicians in breaking bad news	Iran	Cross-sectional survey	200 general physicians (response rate not given)	Educational Hospital	None	Questionnaire based on SPIKES protocol. No detail given about piloting.
Shahi et al., 2020	Assess physicians' performance as well as the importance of their training on how to deliver bad news to patients diagnosed with cancer	Iran	Cross-sectional survey	12 physicians (100%)	Hospital	None	Questionnaire based on SPIKES protocol. No detail given about piloting.
Dafallah et al., 2020	Assess adherence to the SPIKES protocol in breaking bad news	Sudan	Cross-sectional survey	192 doctors (100%)	Teaching Hospital	None	Questionnaire-based on SPIKES protocol. No detail was given about piloting.
Mostafavian et al., 2018	Evaluate the ability and skills of physicians in delivering bad news to cancer patients	Iran	Cross-sectional survey	70 physicians (response rate not given)	2 hospitals	None	Questionnaire based on SPIKES protocol. No detail given about piloting.

Authors, year	Stated aim	Country	Design	Participants, n (response rate)	Setting	Theory	Data collection tool development
Tehran et al., 2019	Evaluate the skill of general physicians in breaking bad news	Iran	Cross-sectional survey	200 general physicians (response rate not given)	Educational Hospital	None	Questionnaire based on SPIKES protocol. No detail given about piloting.
Shahi et al., 2020	Assess physicians' performance as well as the importance of their training on how to deliver bad news to patients diagnosed with cancer	Iran	Cross-sectional survey	12 physicians (100%)	Hospital	None	Questionnaire based on SPIKES protocol. No detail given about piloting.
Dafallah et al., 2020	Assess adherence to the SPIKES protocol in breaking bad news	Sudan	Cross-sectional survey	192 doctors (100%)	Teaching Hospital	None	Questionnaire-based on SPIKES protocol. No detail was given about piloting.
Yazdanparast et al., 2021	Evaluate the effect of communication skills training on the level of skill and participation of nurses in breaking bad	Iran	Semi-experimental study	60 nurses (100%)	Educational Hospital	None	Questionnaire-based on SPIKES protocol. Tested for internal reliability. No detail was given about piloting.

Authors, year	Stated aim	Country	Design	Participants, n (response rate)	Setting	Theory	Data collection tool development
	news						
Rezayof et al., 2022	Design and evaluate a novel virtual instructional design for improving obstetrics and gynecology (OB/GYN) residents' breaking bad news skills	Iran	Virtual instructional design	33 Obstetrics and gynecology (OB/GYN) residents (Response rate not given)	Hospital	None	Questionnaire based on the ADDIE model (Analysis, Design, Development, Implementation and Evaluation). Content preparation included virtual training package multimedia, text, educational slides and videos.
AlZayani et al., 2022	Assess attitudes and practices regarding truth-telling to seriously ill patients	Bahrain	Cross-sectional survey	156 residents and specialist physicians (72%)	Public hospital	None	Questionnaire based on previous study. No detail given about further validity testing or piloting.
Awny et al., 2022	Explore knowledge, attitude, and practice toward palliative care	Egypt	Cross-sectional survey	220 physicians (response rate not given)	University Hospital	None	Questionnaire based on previous study. Validated by expert physicians. No detail given about piloting.
Bazrafshan et al., 2022	Identify the attitudes towards breaking bad	Iran	Cross-sectional survey	397 physicians, patients, and	Hospital	Not given	Questionnaire based on previous studies. Further validation by an expert panel. No detail given about piloting.

Authors, year	Stated aim	Country	Design	Participants, n (response rate)	Setting	Theory	Data collection tool development
	medical news to patients			their families (100%)			
Elashiry et al., 2022	Assess knowledge, attitude, and practice regarding SPIKES protocol for breaking bad news (BBN)	Egypt	Cross-sectional survey	395 physicians (response rate not given)	teaching Hospital	None	A questionnaire based on the SPIKES protocol and Santos et al., BBN attitude scale used was validated by Santos et al. No detail was given about piloting.
Khalaf et al., 2022	Assess the use of non-physical methods in breaking bad news	Iran	Cross-sectional survey	60 physicians (response rate not given)	Hospital	None	Bespoke questionnaire. No detail was given about further validity testing or piloting.
Rayan et al., 2022	Examine critical care nurses' attitudes, roles, experience, education, and barriers regarding breaking the bad news	Jordan	Cross-sectional survey	210 nurses working in ED, ICU, or CCU (response rate not given)	Hospital	None	Questionnaire-based on the previous study. No detail about further validity testing or piloting. Internal reliability confirmed.

2.4.3 Outcomes and key findings of views and experiences, with a focus on positive and negative aspects

The key findings and conclusions derived from each study are given in Table 3. The most common findings were willingness to share bad news, lack of adequate training for breaking bad news, lack of any formal education, discrepancies based on demographics, and lack of awareness and adherence to SPIKES and ABCDE protocols. Conclusions derived from studies revealed a positive trend in breaking bad news and the need for further training on breaking bad news.

Table 3. Key findings and conclusions derived from each study

Authors, year	Key findings	Conclusion
Amiel et al., 2006	• GPs in intervention arm had significant post-test average grade compared to pre-test. • There was minimal improvement in control group.	• BBN training should be validated before application in a healthcare setting. • SPs are reliable evaluators of BBN training.
Arbabi et al., 2010	• A minority of respondents were trained to deliver bad news. • Respondents preferred to deliver bad news to patients alone or in the presence of patients' partners. • A minority agreed that they would explain life expectancy to patients.	• There is an increase in willingness to share bad news compared to the past. • Physicians and nurses lack adequate skills to deliver bad news to patients.
Al-Mohaimeed et al., 2013	• The majority of participants shared bad news with their patients. • The majority preferred to deliver bad news to relatives rather than patients. • Physicians who had higher qualifications were less skilled in breaking bad news.	• The majority of physicians lacked adequate skills to deliver bad news to patients. • There is a need for training in this specific aspect of health care.
Shomoossi et al., 2013	• The majority of nurses did not receive any training in breaking bad news to patients. • Almost all were unfamiliar with SPIKES protocols and were not aware of ABCDE protocols. • All agreed on adopting ABCDE strategies for delivering death notifications.	• There is an urgent need for training nurses regarding communication skills. • Special attention should be given to patients' emotions.
Naji et al., 2014	• More than half of participants agreed to share full truth disclosure with patients. • Most disclosers attributed their disclosure practices mostly to medical education and professional experience.	• There is an increasing trend regarding willingness to disclose bad news to patients. • Disclosure is likely to become a normative practice.

Authors, year	Key findings	Conclusion
Farhat et al., 2015	• Three-quarters of physicians agreed that cancer diagnosis should be shared with patients. • A minority revealed cancer diagnosis. • Only a few would reveal the diagnosis immediately.	• Physicians want to communicate the diagnosis of cancer. • In practice, it is revealed progressively over the course of treatment.
Imanipour et al. 2015	• The majority of respondents had a positive attitude towards the involvement of nurses in breaking bad news. • Almost three quarters had moderate knowledge about breaking bad news to patients. • A minority had good knowledge of breaking bad news.	• Critical care nurses have a positive attitude towards breaking bad news. • They have inadequate knowledge level regarding breaking bad news.
Ozyemisci-Taskiran et al. 2016	• Almost half of the respondents received basic communication skills training. • All agreed that physiatrists should participate in breaking bad news to patients. • More than half believed that the most appropriate time for relaying bad news to patients was during rehabilitation. • A minority told the absolute truth to the patients. • More than half of physicians revealed that they were forced to tell lies to patients.	• There was a difference in the opinions regarding the style of delivering bad news to patients. • There was a lack of satisfaction concerning communication skills. • There is a need for the development of communication skills through training and intervention.
Adeli et al., 2016	• Almost half had an average attitude level regarding breaking bad news to patients. • Male respondents demonstrated superior attitude levels compared to females. • There was a positive relationship between work experience and attitude.	• Most physicians think that withholding bad news from patients is not absolutely prohibited. • While breaking bad news, knowledge, awareness, and age of patients should be kept in mind.
Borgan et al., 2018	• One quarter of the physicians did not share the bad news with their patients. • The majority directly shared bad news with patients.	• The majority of physicians shared bad news with their patients. • In select cases, most will make exceptions.

Authors, year	Key findings	Conclusion
Muneer et al., 2018	• Almost half of respondents received training regarding breaking bad news to patients. • The majority thought that the patient should be told everything about his or her serious illness. • If pressured by a relative to hide the truth, almost half agreed that they would break bad news if the patient was willing to listen. • Only one quarter followed a standardized protocol for breaking bad news.	• A minority of respondents did not follow the protocols, indicating a lack of knowledge. • There is a need for training of healthcare professionals regarding breaking bad news.
Biazar et al., 2019	• Only a limited number of participants received training in delivering bad news. • Only a minority believed that they had the ability to deliver bad news to patients. • No differences were noted among physicians who received training and those who did not.	• There is a need for training of the physicians to deliver bad news to patients.
Mostafavian et al., 2018	• All participants agreed not to tell bad news via telephone. • The majority agreed to tell bad news in private. • More than half believed that patient's knowledge should be assessed before giving bad news.	• Physicians do not have adequate knowledge about breaking bad news. • There is a need to educate physicians regarding breaking bad news.
Tehran et al., 2019	• Most of the respondents did not receive any formal education relating to breaking bad news to the patients. • Almost three quarters shared bad news with the patients, varying according to their experience. • Half agreed that they considered patients' fears while breaking bad news.	• The skill level of the participants was desirable. • There is a need for continuing education programs, especially for general physicians.
Shahi et al., 2020	• More males than females reported that patients have the right to know their diagnosis. • More females than males had effective	• Guidelines can help physicians deliver bad news.

Authors, year	Key findings	Conclusion
	communication with patients when delivering bad news. • Nearly half of physicians had experience in breaking bad news. • More than half agreed that bad news should be delivered directly to the patients. • The majority agreed that further training is needed in breaking bad news. • Adherence to the SPIKES protocol was reported by more than half.	
Dafallah et al., 2020		• The majority of doctors adhere to the SPIKES protocol.
Yazdanparast et al., 2021	• There was significant improvement in breaking bad news related skills post intervention. • Post intervention, there was significant increase in participation in delivering bad news to patients.	• Communication skills are important for breaking bad news. • The intervention could help health professionals in delivering breaking bad news.
Rezayof et al., 2022	• The majority of respondents believed that there was need for specific training, particularly in areas of interview context, strategy, planning, professionalism, empathy, knowledge, and receiving information.	• Most obstetrics and gynecology residents do not have the necessary perceptions and skills to deliver bad news to patients.
AlZayani et al., 2022	• Almost half of respondents believed that patients should always be told about their diagnosis. • One third did not know the breaking bad news policy of the hospital. • The majority did not believe that withholding bad news from the patients was beneficial for them.	• Physicians were not aware of any policies regarding breaking bad news in their hospitals.
Awny et al., 2022	• One third of respondents received education on palliative care. • Around half preferred to break bad news and deliver prognosis to patients.	• There is a need for training of the physicians on palliative care to the patients.
Bazrafshan et al., 2022	• The majority of physicians agreed on sharing bad news with patients.	• The desire to break bad news is lower compared to the tendency to hear bad news.

Authors, year	Key findings	Conclusion
Elashiry et al., 2022	• Most agreed that patients should be given bad news as soon as possible. • Bad experiences of breaking bad news were reported by half of the physicians. • Most physicians preferred breaking bad news to the patient's family rather than the patient. • Physicians' agreement level with the SPIKES strategy was very high.	• The majority of physicians highly agreed with the SPIKES strategy for breaking bad news, but they lacked essential knowledge. • There is a need for further education and training regarding breaking bad news.
Khalaf et al., 2022	• The majority of the participants reported breaking bad news regularly. • Less than half received training on breaking bad news. • Only a minority received training on non-physical (in-person) breaking bad news.	• A high proportion of physicians lack the necessary skills to break bad news, especially using non-physical ways during the pandemic. • Further training of physicians is required.
Rayan et al., 2022	• Most critical care nurses contributed to breaking bad news and had positive attitudes regarding breaking bad news. • The majority reported that they did not receive any specific training regarding breaking bad news. • Nurses face various barriers when breaking bad news.	• Administrators should promote the involvement of critical care nurses in breaking bad news and address the challenges in the process of breaking bad news. • Training courses should also be offered to improve nurses' skills.

Mapping identified groupings of

i. positive views and experiences
ii. negative views and experiences
iii. practice varies with demographics and experience, and
iv. need for education/training.

Table 4 provides the mapping of each study to these groupings, which are described in more detail below.

2.4.3.1 Positive views and experience

There were five themes of positive views and experiences: perceived adequate knowledge/ skills, positive attitude towards breaking bad news, received training, awareness of accepted approaches (e.g., SPIKES/ ABCDE), and adherence to accepted approaches.

2.4.3.1.1 Perceived adequate knowledge/ skills. Of the 24 studies in the review, five reported positive aspects in terms of perceived knowledge and skills being adequate. These studies were all cross-sectional, with the participants in three studies being nurses and physicians in two studies. Of note, Naji et al. (2014) reported an association between higher perceived knowledge/skills with younger age and a high number of weekly practice hours.

2.4.3.1.2 Positive attitude towards breaking bad news. Most of the studies (n=14) included in the review reported participants' positive attitudes regarding breaking bad news. Thirteen were cross-sectional and one reported development of a virtual instructional medium. Six of the studies included physicians, three studies included nurses, two each included physicians/nurses and physicians/residents and one resident only. Arbabi et al. (2010) found an association between older age and experience, and positive attitudes towards breaking bad news.

2.4.3.1.3 Received training. Four studies reported that participants received training regarding breaking bad news. Two had a cross-sectional design, one a semi-experimental study and one a non-randomized controlled study design. All studies were of physicians apart from one which included nurses. The percentage of participants receiving training on breaking bad news was variable, ranging from 15.9% to 50.9%.

2.4.3.1.4 Awareness of accepted approaches (e.g., SPIKES/ ABCDE). Only one cross-sectional of physicians reported that participants had awareness of SPIKES/ABCDE approaches. In this study, Elashiry et al. (2022) reported that 10% were aware of the SPIKES protocol.

2.4.3.1.5 Adherence to accepted approaches. Three studies reported that participants adhered to accepted protocols such as SPIKES or ABCDE while breaking bad news. All were cross-sectional studies of physicians. Elashiry et al. (2022) and Dafallah et al. (2020) reported a very high level of agreement with SPIKES protocols among physicians. According to Muneer et al. (2018), only half of the participants followed SPIKES protocols, with others following their own protocols.

2.4.3.2 Negative views and experiences

There were five themes of negative views and experiences: reported lack of training, unaware of accepted approaches, lack of full disclosure to patients, unaware of institutional policy, and practice varies with demographics and experience.

2.4.3.2.1 Reported lack of training. In nine studies, the respondents reported a lack of training in delivering bad news. These studies were largely cross-sectional, with five studies including physicians, two physicians/residents, one nurses, and one physicians/nurses. The remaining studies did not report any aspect of training.

2.4.3.2.2 Unaware of accepted approaches. One study reported that participants were unaware of the accepted approaches for breaking bad news. In a cross-sectional

of included nurses, Shomoossi et al. (2013) reported that almost all participants were unaware of SPIKES and ABCDE protocols.

2.4.3.2.3 Lack of full disclosure to patients. Nine studies reported that participants did not disclose bad news in full. These cross-sectional studies were largely of physicians, with nurses also included in one study. Arbabi et al. (2010), reported that a minority of physicians would always discuss patients' diagnoses compared with two thirds of nurses. Of note, nurses' practice was largely directed at families and not the patients themselves. Similarly, Al-Mohaimeed et al., (2013) reported that almost three quarters of respondents delivered bad news to relatives rather than patients. Farhat et al., (2015) also reported that a minority of physicians broke bad news to their patients. Only one fifth of the respondents in a study by Ozyemisci-Taskiran et al. (2016) told the 'absolute truth' to patients, with remainder 'partial truth'. Borgan et al., (2018) and Muneer et al. (2018) reported that for most physicians, non-disclosure of bad news to patients was requested by family members. According to Elashiry et al. (2022), most physicians avoided delivering bad news directly to patients, opting for discussion with family members.

2.4.3.2.4 Unaware of institutional policy. In a cross-sectional study, AlZayani et al. (2022) reported that one third of physicians and residents were not aware of the institutional policy on breaking bad news.

2.4.3.3 Practice varies with demographics and experience

In five cross-sectional studies of physicians, it was noted that breaking bad news practice varied with the demographics and experience of the participants. For example, Al-Mohaimeed et al. (2013) demonstrated that primary healthcare physicians were the least reserved while breaking bad news to the patients. Naji et al. (2014) reported that disclosers were more involved in teaching compared to non-disclosers while Tehran et

al. (2019) reported significant differences between different age groups.

2.4.3.4 Need for education/ training

In most studies (n=17), the authors reported the need for education and training regarding breaking bad news. Of the 17 studies, ten were of physicians, four nurses, two physicians/residents/nurses and one resident. Most studies (n=15) were cross-sectional, and two semi-experimental with virtual instructional design.

Table 4. Synthesis of literature identifying positive and negative views and experience

Authors, year	Positive views and experiences					Negative views and experiences					
	Perceived adequate Knowledge/ skills	Positive attitude towards breaking bad news	Received training	Awareness of accepted approaches (e.g., SPIKES/ ABCDE)	Adherence to accepted approaches	Reported lack of training	Unaware of accepted approaches	Lack of full disclosure to patients	Unaware of institutional policy	Practice varies with demographics and experience	Need for education/ training
Amiel et al., 2006			✓								
Arbabi et al., 2010		✓				✓		✓			✓
Al-Mohaimeed et al., 2013								✓		✓	✓
Shomoossi et al., 2013		✓				✓	✓				✓
Naji et al., 2014	✓	✓								✓	
Farhat et al., 2015		✓						✓			
Imanipour et al., 2015	✓	✓									✓
Ozyemisci-Taskiran et al., 2016		✓	✓					✓			✓

Authors, year	Positive views and experiences					Negative views and experiences					
	Perceived adequate Knowledge/ skills	Positive attitude towards breaking bad news	Received training	Awareness of accepted approaches (e.g., SPIKES/	Adherence to accepted approaches	Reported lack of training	Unaware of accepted approaches	Lack of full disclosure to patients	Unaware of institutional policy	Practice varies with demographics and experience	Need for education/ training
Adeli et al., 2016								✓		✓	
Borgan et al., 2018								✓			
Muneer et al., 2018		✓	✓		✓			✓			✓
Biazar et al., 2019						✓					✓
Mostafavian et al., 2018						✓		✓			✓
Tehran et al., 2019	✓					✓				✓	✓
Shahi et al., 2020		✓								✓	✓
Dafallah et al., 2020	✓				✓						✓
Yazdanparast et al., 2021	✓		✓								✓
Rezayof et al., 2022		✓				✓					✓

Authors, year	Positive views and experiences						Negative views and experiences					
	Perceived adequate Knowledge/ skills	Positive attitude towards breaking bad news	Received training	Awareness of accepted approaches (e.g., SPIKES/	Adherence to accepted approaches	Reported lack of training	Unaware of accepted approaches	Lack of full disclosure to patients	Unaware of institutional policy	Practice varies with demographics and experience	Need for education/ training
AlZayani et al., 2022		✓							✓		
Awny et al., 2022		✓				✓					✓
Bazrafshan et al., 2022		✓									
Elashiry et al., 2022				✓	✓			✓			✓
Khalaf et al., 2022		✓				✓					✓
Rayan et al., 2022		✓				✓					✓

2.4.4 Identify gaps in the literature

Most studies included in this scoping review had a quantitative, cross-sectional design, with few studies employing qualitative approaches to generate rich data. In addition, no study used theory in the development of data collection tools or in the stages of data analysis. Few studies focused on aspects of knowledge and application of SPIKES and ABCDE protocols. There are therefore significant gaps in terms of study design and conduct.

2.5 Discussion

2.5.1 Key Findings

Twenty-four studies were identified in this scoping review of the peer-reviewed literature on health professionals' views and experiences of breaking bad news in the WHO Eastern Mediterranean region. Studies were largely from Iran and were of cross-sectional survey design, with no studies reporting the use of theory in data collection tool development or data analysis. Most studies included physicians with very few reporting data from nurses and none from other health professional groupings. Mapping of study results generated four major areas of findings: including positive views and experiences (perceived adequate knowledge/ skills, positive attitude towards breaking bad news, received training, awareness of accepted approaches (e.g., SPIKES/ ABCDE), adherence to accepted approaches); negative views and experiences (reported lack of training, unaware of accepted approaches, lack of full disclosure to patients, unaware of institutional policy); practice varies with demographics; and experience, and need for education/training.

2.5.2 Strengths and Weaknesses

There are several strengths and weaknesses to this scoping review which should be borne in mind while interpreting the findings. The scoping review adhered to the

Joanna Briggs Institute's method for scoping reviews and followed the Preferred Reporting Items for Systematic Reviews and Meta-analyses extension (PRISMA-ScR) for reporting scoping reviews. Best practice was followed in terms of two independent reviewers being involved in the stages of database searching, title/abstract and full text screening, data extraction and mapping. The main weakness of the review is that only papers published in English were included; the inclusion of Arabic databases may have realized additional studies. While not weaknesses of the conduct and reporting of the review itself, the findings and conclusions are limited by the absence of qualitative studies and the absence of theory in data collection and analysis. Most studies provided limited details of the development of questionnaire domains and items. Response rates were also variable with a number of studies not quantifying the response rate.

2.5.3 Interpretation

The findings of this scoping review align with existing literature on breaking bad news, emphasizing the global challenge of health professionals in effectively communicating bad news to patients. While there were positive themes of participants' perceptions of adequate knowledge and skills, having received training and being aware of accepted approaches, a number of studies also reported negative aspects. These surrounded a reported lack of training and being unaware of accepted approaches. An expressed need for training was reported in most studies. These findings resonate with the broader literature in other parts of the world also reporting issues relating to training and accepted models of practice (Warrier & Pradhan, 2020). Bousquet et al. conducted a meta-synthesis of 40 studies which reported that difficulty in breaking bad news was attributed to lack of physician training (Bousquet et al., 2015). A systematic review by Sharif et al. also reported suboptimal training in breaking bad news in 14 studies that primarily focused on health professionals' training on breaking bad news (Sharif et al.,

2023).

There is a convincing evidence base for training in breaking bad news leading to improvements in practice. A scoping review by Chow et al. reported that physicians who received training were more likely to experience personal accomplishment and less likely to feel emotional exhaustion and depersonalization (Chow & DBioethics, 2017). Similarly, a meta-analysis of 17 studies identified that training interventions were associated with large, significant improvements in observer-rated news delivery skills (Johnson & Panagioti, 2018a).

Despite the issues identified in the scoping review relating to aspects of training, the participants in most studies reported positive attitudes towards breaking bad news and accepted this as an important task. It is therefore of particular interest that the results of many studies also highlighted negative aspects in terms of lack of full disclosure of bad news. In many studies, the health professionals reported partial disclosure to patients or opting to discuss bad news with the families and not the patients themselves. While Bousquet et al described the need to involve family members in the coping mechanism for patients receiving bad news (Bousquet et al., 2015), these scoping review findings may be more associated with the culture and religion in the Eastern Mediterranean region as opposed to the emphasis on individualism, respect for patient autonomy, full diagnosis disclosure, and litigiousness, all of which may impact breaking bad news in western countries (Zhang et al., 2021).

There was a noticeable lack of the application of theory in all studies. Inclusion of theory (e.g., behavioral) in the development of data collection tools, data analysis and interpretation enhance research robustness and rigor. Importantly, use of behavioral theory will allow consideration of all possible influences on, and explanations for behavior. The lack of theory in the studies may be one reason that few studies reported

issues of negative impact on health professionals' emotions, fatigue and burnout which have been reported in other related reviews (de Freitas Domingues, 2016; Francis & Robertson, 2023).

The studies captured were largely cross-sectional and while these are appropriate to quantify views and experiences, they lack the depth of data generated via qualitative research methodologies. It is also noticeable that half of the studies were from Iran with no uniform representation of the WHO Eastern Mediterranean region. The majority of studies reported the perspectives of physicians, with less nurses and none of other health professions. Given the multidisciplinary nature of healthcare and the increasingly clinical role of other health professionals, it is likely that the delivery of bad news may no longer be solely within the domain of physicians. Training and practice of other health professionals warrants further investigation.

2.6 Conclusion

In conclusion, this scoping review offers a comprehensive mapping of existing literature on health professionals' views and experiences of breaking bad news in the Eastern Mediterranean region. The findings revealed both positive and negative aspects while highlighting persistent challenges, with emphasis on the need for targeted training programs and the development of culturally sensitive communication protocols. While the review provides valuable insights further research, particularly using qualitative methodologies, is warranted.

2.7 Future Research

Building on the current review, future research should focus on qualitative investigations to gain a deeper understanding of health professionals' views and experiences and perspectives when breaking bad news. Qualitative data can provide nuanced insights into the cultural factors influencing communication practices. There is also merit in further research which focuses on training in breaking bad news. The

next chapter describes the final phase of this research, which encompasses both key aspects.

CHAPTER 3

3.1 Introduction

The scoping review presented in the preceding chapter identified limitations of the literature in terms of qualitative studies and studies that provided data on views and experiences relating to breaking bad news training. In addition, no studies in the review had been conducted in Qatar.

3.1.1 Local context

Qatar is a country located on the northeastern coast of the Arabian Peninsula, bordering the Persian Gulf. Its landscape is predominantly arid. Despite its size (11,571 km^2), Qatar plays a significant role on the international stage, largely due to its vast reserves of oil and natural gas. The country has one of the highest per capita incomes in the world and a highly developed economy. According to Trading Economics, GDP per capita in Qatar is expected to reach USD 66,346.00 by the end of 2024 (ECONOMICS, 2023). The population of Qatar is diverse; while it includes native Qataris, a large proportion consists of expatriates from around the world, making it a blend of cultures and traditions.

Qatar's vision for healthcare is ambitious and forward-thinking, aiming to develop a system that is among the best in the world in terms of quality, accessibility, and patient care. This vision is encapsulated in the National Health Strategy, which emphasizes preventive care, the integration of advanced technologies, and a patient-centered approach (ALSHAMARI, 2017). The healthcare system in Qatar is a mix of public and private sectors, with the government playing a key role in healthcare provision and financing. The public healthcare system is accessible to all residents, offering services either free of charge or at a nominal cost, while the private sector complements the public services by providing additional options for care.

The Qatari healthcare structure is designed to ensure that services are efficiently distributed across the country. Primary healthcare centers offer basic and preventive services, secondary care hospitals provide more specialized treatments, and tertiary care institutions deliver highly specialized care, often for more complex conditions. Hamad Medical Corporation (HMC) is the premier provider of secondary and tertiary healthcare services in Qatar (HMC, 2024). It is a non-profit healthcare provider and the largest healthcare organization in the country, operating most of the public hospitals and clinics.

HMC embodies Qatar's healthcare ambitions, offering a wide range of medical services and specialties. It operates numerous hospitals, including general hospitals, a women's hospital, a children's hospital, and specialized facilities for rehabilitation, orthopedics, etc. HMC is also at the forefront of medical research and education in the region, collaborating with international institutions to advance medical science and train the next generation of healthcare professionals. It plays a crucial role in implementing the National Health Strategy, working towards improving healthcare outcomes, enhancing patient experiences, and integrating innovative healthcare solutions to meet the needs of Qatar's diverse population.

3.1.2 Communications Skills Workshop

In 2013, a structured communication workshop was first introduced at HMC. Since then, it has become mandatory for training and institutional requirements. Furthermore, it is also a pre-requisite of the Accreditation Council for Graduate Medical Education (ACGME), which accredits residency and fellowship programs at HMC. The ACGME, originally established in the United States (US) in 1981, is a non-profit organization responsible for accrediting medical residency and internship programs. Recently, they have extended their accreditation status beyond the US. HMC

is the first institution in Qatar and the second outside the US to receive ACGME accreditation. The ACGME has six core competencies, with interpersonal communication being a pivotal component. There was a pressing need for such communication skills workshops within the medical community in Qatar. Most of the medical professionals, both trainees and faculty, come from institutions where the concept of patient-centered care is less well established. Many do not follow a competency-based curriculum, and often communication with patients is paternalistic. The workshops aim to address these gaps in communication skills. Effective communication is vital in the medical field. Improved communication leads to better patient adherence to treatment plans, enhanced quality of treatment, and, ultimately, superior health outcomes. Conversely, miscommunication or the omission of crucial information can result in misunderstandings, patient complaints, and even legal issues.

Initially, the workshop duration was two days, covering seven modules. These modules included sessions on *Breaking Bad News*, *Shared Treatment Decision Making, Responding to Patient Anger, communicating via Untrained Interpreters, Discussing Prognosis, Discussing End of Life and DNAR,* and *Conducting a Family Meeting*. The first day comprised four modules, each featuring a lecture followed by face-to-face scenarios. On the second day, three modules were covered using a similar structure. However, a change was forced to this model during COVID-19 due to pandemic restrictions. The interpersonal workshop was then solely conducted online through Microsoft Teams. In 2021, Dr. Abdulla Yousuf took the lead of the communication skills workshop. The concept of "blended meetings," combining both online and face-to-face components, was introduced. The workshop was maintained as a flipped class with the provision of theoretical work in advance via Microsoft Teams. All pre-recorded lectures are uploaded for the participants to gain an understanding of

the seven workshop modules. This preparatory phase aims to familiarize participants with the theoretical concepts and set the stage for more interactive face-to-face scenarios. On the first day of the workshop, the participants take a workshop on theoretical aspects. On the second day, the focus is shifted to face-to-face interactions. During practical engagement sessions, a designated participant, often a consultant, assumes the role of a facilitator. A standardized patient (actor) is also incorporated into the session, presenting specific scenarios. Each participant, one by one, engages in role-playing exercises, interacting with the standardized patient in diverse scenarios. After each role-play, there is a discussion on how well the resident performed. Initially, the facilitator provides feedback on the resident's performance. This is followed by an open discussion with other participants, allowing everyone to share their thoughts. Additionally, the standardized patient and the residents themselves provide feedback. This feedback highlights areas where improvement is possible.

3.1.3 Research phase

The second phase of the Master's thesis was primary research to generate data on the experiences of resident doctors at Hamad Medical Corporation in breaking bad news three months after participating in the Communication Skills workshop which included Breaking Bad News as one of its seven modules.

3.2 Aim and Objectives

This research aimed to explore the related experiences of resident doctors three months after participating in the breaking bad news workshop.

The specific objectives were:

- To explore any positive or negative aspects of the workshop.
- To explore the perceived impact of training on breaking bad news practice.
- To explore any future training needs.

3.3 Method

3.3.1 Design

This was a qualitative study. Qualitative studies explore the how and why of topics of interest using qualitative data such as narratives, conversations, and discourses (Burck, 2005).

3.3.2 Setting

The research setting for the current study was Hamad Medical Corporation, Qatar. The study participants were medical residents employed by the establishment; the sample was drawn from the resident doctors three months after undergoing breaking bad news training.

3.3.3 Participants

The sampling frame was medical residents attending breaking bad news training provided by HMC.

3.3.3.1 Inclusion criteria

- Employed by HMC as a medical resident
- Attended training on breaking bad news

3.3.3.2 Exclusion criteria

- Involved in the pilot phase of the research
- Those who could not attend at least 80% of the training session the assessment conducted as part of the workshop.

3.3.4 Sampling and sample size

A purposive maximum variation sampling was used to identify participants; a non-random sampling technique in which participants are chosen because they have some characteristics required for the study (Sawatsky et al., 2019). Individuals meeting

the inclusion criteria were sampled in strata of specialty, gender, and country of undergraduate and graduate training. The sample size was guided by the point at which data saturation occurred (i.e., the point at which no new themes are generated). It was estimated that around 10 participants would be sufficient to allow the study to achieve data saturation based on the literature on qualitative studies using a similar data generation method.

3.3.5 Recruitment

Purposively sampled individuals were contacted via email by the principal investigator 3 months following completion of the workshop. They were provided with full study information and notified that participation in the study would have no effect on the training. Those agreeing to participate were requested to provide signed consent prior to any fieldwork. They were also required to confirm their willingness to participate in the follow-up interview.

3.3.6 Development of interview schedule

The interview schedule was developed from the findings of the scoping review and grounded in the Context, Input, Process and Product (CIPP) model (Zhang et al., 2011). This model is described in four phases of

- Context evaluation (goal identification)
- Input evaluation (plans)
- Process evaluation (actions)
- Product evaluation (outcomes)

The schedule was reviewed for credibility by individuals with expertise in qualitative research (n=3). The final interview schedule is given in Appendix B.

3.3.7 Piloting

Pilot-testing of the interview tool was undertaken with one resident doctor who

had attended the training. As a number of modifications were made to the interview schedule post-piloting, the pilot data were not included in the dataset for analysis.

3.3.8 Data generation

A semi-structured interview technique was used for data generation. This technique allows for the collection of rich data as the researcher has the freedom to ask probing questions to obtain deeper insights, and the interviewees equally have the freedom to expand on issues relating to their experiences. The interviews were conducted by a researcher with training in qualitative interviewing. Interviews of around 45 minutes were conducted face to face in a private office on a date and at a time convenient to the participants. The interviews were recorded (with consent) and the transcripts checked for accuracy prior to analysis. Interviews were conducted between September 2023 and January 2024.

3.3.9 Analysis

The analytical framework that was used for the study was Castleberry and Nolen's (2018) analytic framework, which outlines five steps.

1. Compilation of data
2. Data disassembly or coding – this step involves generating codes, units of meaning and repetitive expressions from the data
3. Reassembly of data or theming – this step consists in generating themes from the data, phrases "that captures something important about the data concerning the research question and represents some level of patterned response or meaning within the data set"
4. Interpreting
5. Drawing conclusions.

The transcripts of all interviews were double coded by two independent

researchers. To establish the coding framework, all researchers coded the same two interviews and all codes collated and summarized (see Appendix C). Detailed notes were made throughout the research, including all steps of analysis to encourage reflexivity.

3.3.10 Ethics approval

The study was conducted in full conformance with principles of the "Declaration of Helsinki," Good Clinical Practice (GCP), and within the laws and regulations of the Ministry of Public Health in Qatar. Ethics approval was obtained from HMC (MRC-01-23-157, Date: 06/03/2023) and Qatar University (2026955-1, 20/09/2023) (Appendix D and E, respectively). All participants signed a specific consent form prior to the interview (Appendix F).

3.4 Results

Ten workshop participants were interviewed. Limited details are provided to protect anonymity. Three were from general surgery, with the others from different medical specialties. There were seven males and three females.

Table 5. Demographic details of participants

Participants	**Medical Specialty**	**Gender**
1	General Surgery	Male
2	General Surgery	Male
3	Accident and Emergency	Female
4	Obstetrics and Gynecology	Female
5	Psychiatry	Male
6	Orthopedics	Male
7	Dermatology	Male
8	Internal Medicine	Male
9	General Surgery	Female
10	Urology	Male

3.4.1 Thematic analysis

Four major themes emerged in the study: (i) related to experiences of breaking bad news; (ii) related to assessment of training needs; (iii) related to the workshop program,

(iv) and related to post-workshop evaluation. The themes and subthemes are given in Table 6. The themes related to the workshop are mapped to the CIPP model

Themes	Sub-themes	CIPP model
1. Related to experiences of breaking bad news	1.1 Benefits of breaking bad news 1.2 Role of communication, empathy, trust 1.3 Negative impact of breaking bad news 1.4 Challenges, patient, family 1.5 Challenges resources (time available, documentation, setting)	-
2. Related to assessment of training needs	2.1 Expressed need for training	Context (Assessment of training needs)
3. Related to the workshop program	3.1 Experiences of simulation, roleplay and real-life scenarios 3.2 Workshop experiences	Input and process (The training program)
4. Related to post-workshop impact	4.1 Impacting systematic approach 4.2 Impacting message delivery 4.3 Long lasting impact	Product (Impact on practice)

3.4.1.1 Theme 1. Experiences of breaking bad news

Interviewees described their experiences of breaking bad news prior to participation in thw workshop.

3.4.1.1.1 Subtheme 1.1. Benefits of breaking bad news

Interviewees were of the view that breaking bad news is a critical skill for health professionals, noting benefits for patients and their families. The need for communication which was empathetic and compassionate was highlighted.

"The benefits when bad news is delivered compassionately and effectively, patients and families feel heard, understood, and supported during this difficult time, physicians decrease the likelihood of misunderstandings as it is clear empathetic communication and the healthcare system as good communication has the potential to improve patient outcomes"

[Interviewee 3, female, A & E]

There was comment that while breaking bad news was generally not welcomed by patients, the manner in which the news was delivered could be beneficial.

"I think everyone benefits from breaking bad news. Well, no one wants to be the one to give a patient bad news, and no one wants to be on the receiving end of bad news. So, it's definitely a skill and a talent to be able to convey your message while being empathetic and sympathetic to patients. So, I think all patients benefit from breaking bad news in a good way."

[Interviewee 1, Male, General Surgery]

Breaking bad news also had some benefits for the health professionals.

"Both the patient and the physician benefit from the skillful delivery of bad news…For the physician effective communication can foster trust and compliance which are critical for a successful treatment outcome."

[Interviewee 7, Male, Dermatology]

3.4.1.1.2 Subtheme 1.2. Role of communication, empathy, trust

The need to be skilled in communication was highlighted by all interviewees, with the terms 'empathetic', 'sympathetic', 'trust' and 'compassionate' commonly used. There was awareness that the manner in which bad news was broken was a major factor in the outcome of the consultation.

"The way we communicate bad news can significantly impact the patient's ability to understand the situation. make informed decisions and cope with their emotions. And so, mastering the skill is fundamental to practicing compassionate patient-centered care."

[Interviewee 4, female, Ob-Gyn]

"Breaking Bad News is a crucial skill in our field. It is not just about conveying the

news itself. But how do we do it? empathy and compassion are at the core; we need to consider the patient's also mental health and emotional state and how the news might impact them."

[Interviewee 2, Male, General Surgery]

"Doing this for sensitivity can greatly influence how they cope with the news. It's not just about delivering the news, but also about providing support and understanding the emotional impact that may have." *[Interviewee 8, Male, Internal Medicine]*

3.4.1.1.3 Subtheme 1.3. Negative impact of breaking bad news

Interviewees also discussed the potential consequences of poor delivery of bad news to patients.

"Poor delivery can lead to miscommunication, mistrust, and the damaging emotional impact on the patient." *[Interviewee 7, Male, Dermatology]*

"If bad news is broken poorly, the consequences are devastating. Imagine a patient who feels rushed, confused, or abandoned during that critical conversation. The trauma of that experience can severely damage patient trust in the medical field and even delay in a surgery."

[Interviewee 9, Female, General Surgery]

3.4.1.1.4 Subtheme 1.4. Challenges, patient, family

Challenges experienced when breaking bad news were discussed at length. Several interviewees noted challenges due to cultural and linguistic issues.

"Despite my best efforts to communicate sensitively, the language barrier impeded our understanding this was deemed negative from all perspectives as the message wasn't conveyed as effectively as I intended" *[Interviewee 8, Male, Internal Medicine]*

"I'm better at recognizing the different ways people react about news. Some need information someone to vent their anger other shut down completely."

[Interviewee 3, Female, A&E]

There were also challenges from the wider family and not just the patient.

"The patient and the family struggled to accept the reality viewing the news is overly negative and hopeless. This perspective reflected in their feedback and emotional response highlighted the difficulty in balancing hope with honesty especially when the expectations are misaligned with medical realities"

[Interviewee 4, Female, Ob-Gyn]

3.4.1.1.5 Subtheme 1.5. Challenges resources (time available, documentation, setting)

There were also logistical challenges in relation to breaking bad news, largely issues of time, documentation and setting.

"One of the main barriers has been time constraints in a busy clinical setting which can make it challenging to implement a structured approach."

[Interviewee 4, Female, Ob-Gyn]

"Sometimes the logistics are difficult that are busy hospitals, finding a quiet space managing interruptions that requires coordination with the rest of the team."

[Interviewee 9, Female, General Surgery]

The following themes were mapped to the CIPP model.

3.4.1.2 Mapped to Context - Theme 2. Assessment of training needs

3.4.1.2.1 Subtheme 2.1 Expressed need for training

All interviewees were of the view that they had a need for training to refine their skills.

"Regular debriefing with colleagues may be an even smaller workshop, especially for psychiatrists is focused on refining these communication skills under the unique pressure we face."

[Interviewee 5, Male, Psychiatry]

One interviewee commented on the for development of cultural competence related skills, particularly for those practising in a country different to that of their own background.

"I would say incorporating more interactive sessions on I would say cultural competencies for foreign physicians to understand the cultural background of the people living here, I will say the diversity people living here are caught up."

[Interviewee 10, Male, Urology]

Some aspired to have skills in breaking bad news at the same level as their seniors.

"I've seen some of our senior consultants handle these incredibly difficult situations with such grace and I wanted to learn from them. I was hoping for practical skills and maybe a deeper understanding of how to balance the medical facts with genuine empathy." *[Interviewee 3, Female, A&E]*

3.4.1.3 Mapped to Input and processes - Theme 3. Workshop program

3.4.1.3.1 Subtheme 3.1 Experiences of simulation, roleplay and real-life scenarios

There was extensive discussion on the workshop program itself, with all interviewees expressing positive views and experiences. They particularly valued the simulation, role-playing and real-life scenarios, articulating their desires for additional training of this nature. Real-life scenarios were viewed as being particularly appropriate for dealing with the emotional and sensitive aspects of breaking bad news.

"*For the most part, yes, it's been incredibly helpful, though. I would love more time for*

role-playing scenarios, practicing is one thing but dealing with the unpredictable emotions of a real-life patient and their family is a whole different challenge."

[Interviewee 3, Female, A&E]

"I would say support from my senior colleagues and also what have learned through the roleplay exercises at the workshop." [Interviewee 10, Male, Urology]

Feeback on performance during roleplay was noted as being particularly valuable.

"It wasn't just knowledge it was the roleplay scenarios and feedback from instructors that made the difference." [Interviewee 9, Female, General Surgery]

"The roleplay in particular, where I had an opportunity to engage in real-life scenarios was beneficial. It allowed me to apply the skills and techniques layered in a hand on sitting, improving my confidence and readiness for challenging conversations."

[Interviewee 2, Male, General Surgery]

3.4.1.3.2 Subtheme 3.2 Workshop experiences

Many interviewees expressed their enjoyment of participating in the workshop. The opportunity to develop skills was highly appreciated, with some highlighting the need for regular reinforcement.

"I actually liked the workshop so much that I think healthcare providers should be reminded of these skills more often. So, I would do a repeat of less."

[Interviewee 1, Male, General Surgery]

Others noted that they now had a more systematic approach.

"It's definitely less stressful for me even though delivering values is never going to be easy. I'm less afraid of it now. I feel like I have a toolkit whereas before I was just searching in the dark. And for my interactions with patients and families that sense of difference." [Interviewee, Female, A&E]

"The workshop has definitely provided the framework but equally impactful has been observing senior surgeons who do this well, seeing how they balance honesty with empathy, how they had an emotional outburst without getting defensive."

[Interviewee 6, Male, Orthopedics]

3.4.1.4 Mapped to Product - Theme 4. Post-workshop impact

3.4.1.4.1 Subtheme 4.1 Impacting systematic approach

The impact of the workshop on breaking bad news using a more systematic approach was reported may interviewees, with emphasis on frameworks, protocols and tools.

"The structure protocols and communication tools we learned during the workshops have been instrumental in guiding my practice and giving me a solid foundation to rely on during these conversations."

[Interviewee 4, Female, Ob-Gyn]

"It was highly effective, I now have a clear framework for these discussions, which has made me more confident in my ability to handle them with I would say sensitivity."

[Interviewee 10, Male, Urology]

3.4.1.4.2 Subtheme 4.2 Impacting message delivery

Many felt that their delivery of bad news had improved following participation in the workshop. There were perceptions that their stypes of commication had altered, taking more time and giving space for patient reflection.

"The most significant change has been the shift in my communication style. I'm more patient and less hurried."

[Interviewee 7, Male, Dermatology]

"After I deliver the news, I give space for the person to react then ask what they've taken in the residence situation where you think you've explained things clearly, but

they've been in too much shock to absorb anything."

[Interviewee 3, Female, A&E]

"The workshop also emphasizes the importance of empathy. And actively listening to the patient's concerns, which has completely changed how I approach these conversations."

[Interviewee 9, Female, General Surgery]

3.4.1.4.3 Subtheme 4.3 Long lasting impact

Several interviewees also alluded to the long-lasting impact of the workshop on their practice of breaking bad news.

"Since the training I feel more equipped and less anxious about breaking bad news. It's never easy, but I feel that I'm doing a better service to my patients, handling families and friends requires sensitivity, and the training has helped me engage with them more effectively."

[Interviewee 8, Male, Internal medicine]

"These are never pleasant conversations, but I have a much greater sense of control and purpose. Those moments where I used to feel hopeless or replaced by feeling, however difficult that I'm doing my best for the patient at a critical time."

[Interviewee 9, Female, General Surgery]

3.5 Discussion

3.5.1 Statement of key findings

Ten interviewees from a range of specialties participated in this qualitative study following their participation in bespoke training on breaking bad news. Four themes and a number of subthemes emerged from the data analysis. One theme related to the experiences of breaking bad news, with five associated five subthemes. Benefits of

breaking bad news were described for the patients, families and the health professionals, with acknowledgement that breaking bad news is an essential skill which can impact patient outcomes. The quality of communication was deemed to have significant importance, highlighting the need for empathy and trust and the profound impact of communication style on the outcomes of breaking bad news. When bad news was not delivered in an appropriate manner, it was viewed as being traumatic for all involved and could potentially exacerbate the underlying condition of the patients. Specific challenges were highlighted, particularly those related to cultural, linguistic, patient, and family issues. There were also challenges related to setting, time, and documentation. Three themes were mapped to the CIPP model in terms of aspects of the training workshop. The first of these related to context in terms of the assessment of training needs. Notably, all interviewees were acutely aware of their needs for training in breaking bad news to foster skills development. The second training theme related to the actual workshop program, with interviewees particularly appreciative of the workshop in general and notably the emphasis on simulation, role-playing and real-life scenarios. The final theme related to the product domain of CIPP in terms of the post-workshop impact. Interviewees commented that the workshop provided them with a systematic approach to deliver bad news which had impacted the delivery of the messages. Interviewees also reported that workshop was likely to have a long-lasting impact on their abilities to deliver bad news.

3.5.2 Strengths and weaknesses

The key strength of this study is the qualitative approach which provided rich data from the interviewees based on human experience (Cleland, 2017). The findings of the scoping review presented in the last chapter highlighted the lack of qualitative research in the region which focused on breaking bad news. There was also a lack of research

on the perceptions of health professionals in relation to training needs and experiences following training. The research was conducted three months following participation in the workshop to allow sufficient time for reflection on the workshop and integration of workshop materials and approaches into daily practice. One further strength of the study was the utiization of the CIPP evaluation model as a framework for the development of the interview schedule, data analysis and interpretation. Evaluation transforms education from a static state to a dynamic one. There are several models to evaluate education programs, with CIPP being one of the most widely used. The CIPP evaluation model comprehensively addresses all phases involved in refining an educational program hence is appropriate for evaluating the complex nature of education programs (Toosi et al., 2021). Throughout the research, attention was paid to aspects of trustworthiness. For example, credibility was promoted by adopting well established research methods, the use of probing questions, and review of the interview schedule by experts in qualitative studies. Transferability was promoted through thick description of the research setting and participants (whilst protecting anonymity). Dependability was promoted through the detailed approach to data collection and analysis.

The are some limitations of the study which should be kept in mind while interpreting the findings of the study. First, there was difficulty in recruiting the participants, with only ten recruited throughout the study hence it is possibly that data saturation may not have been achieved. As the study was conducted in the HMC in Qatar, the findings may not be transferable to other settings and countries in the region and beyond.

3.5.3 Interpretation

In this qualitative study, interviewees reflected on their practice in breaking bad news prior to attending the workshop. The theme relating to these experiences and the five

associated subthemes resonate with some of the findings of the scoping review presented in chapter 2 and reviews and studies conducted in other parts of the world. Others have reported the impact of bad news on individuals spanning the patients, families and health professionals ((Back et al., 2005); Beyraghi et al., 2011; Almansour & Abdel Razeq, 2021; Francis & Robertson, 2023; (Garnett et al., 2023). The interviewees were aware of the need for high level communication skills whilst breaking bad news and that that these skills required significant training and practice. Recent studies have also highlihed health professionals' desires for further training in breaking bad news (Ferraz Gonçalves et al., 2017; Yi et al., 2022). Of note, the interviewees in this study highlighted the significant impact of this communication on patients' ability to comprehend the situations, make decisions, and cope with their emotions. They emphasized the importance of balancing medical facts with genuine empathy. An empathic understanding a patient's needs is essential for developing a therapeutic doctor-patient relationship (Eby, 2018). Poor delivery of bad news can lead to miscommunication, mistrust, and emotional distress for patients. Therefore, sensitivity and understanding during these critical conversations is fundamental. An important finding of this study which has been less reported are the challenges imposed by not only cultural but also linguistic barriers hence these must feature in any training. This requirement has also been voiced by others (Walker & Sivell, 2022).

The CIPP model places emphasis on the context for training (the what should we do?). In this study, one theme related to the assessment of training needs with interviewees expressing their own needs for training in breaking bad news. This self-awareness is reassuring and was also a major finding of the scoping review with the authors of many studies either reporting or concluding the need for training. This need also extended to aspects of cultural competencies, which was noted to be a key issue given the large

expatriate population in Qatar and hence the challenges of both patients' needs and the varied backgrounds of the health professionals (Bylund et al., 2017).

The input element of the CIPP model (how should we do it?) relates to the planning part of the training and the process (are we doing it as planned?) to how well the training program was implemented. The interviewees placed less emphasis on the input element but were overwhelmingly positive in relation to the process. They were particularly appreciative of the style of the workshop with its emphasis on simulation, roleplay and real-life scenarios. There is an extensive evidence base that such approaches can offer participants with tools that are applicable in real world scenario (JM, 2019)

The product element of the CIPP model (did the program work?) relates to impact. In this study, the impacts described by the participants are perceptions and not objective measures of impact on processes or outcomes. However, these are encouraging and should not be underestimated. It is reassuring that one subtheme related to the impact on a more systematic approach. Key negative findings of the scoping review were the degree of poor awareness of accepted approaches (e.g., SPIKES/ ABCDE) to breaking bad news and being unaware of institutional policies and guidelines. As highlighted in chapter 1, there is an extensive evidence base on the use of these validated protocols and the subsequent positive outcomes of their use in both training and practice (Baile et al., 2000; Monden et al., 2016). While interviewees noted that the workshop had impacted their practice, further research is required to explore their perspectives on the longer-term impact on practice and more objective measures of impact. Interviewees did themselves highlight the need for ongoing training which should be considered by health institutions.

3.5.4 Conclusion

In conclusion, this qualitative exploration of health professionals' experiences regarding

breaking bad news and related training has provided insight into various aspects of breaking bad news. The findings highlight the multifaceted nature of delivering bad news, with particular emphasis on empathy, compassion and trust, with awareness of the possible positive and negative outcomes for all involved. The training related themes mapped to the CIPP evaluation model highlighted themes related to the acute awareness of the need for training, the regard for the training workshop and the perceived impacts on practice. Further research is required to focus on these longer terms impacts with consideration of quantitative measures of outcome.

CHAPTER 4:

4.1 Statement of Key Findings

The overall aim of the research was to explore health professionals' approaches to breaking bad news in the WHO Eastern Mediterranean Region. The research was further divided into two phases. The first phase was a scoping review of the peer-reviewed literature on health professionals' views and experiences of breaking bad news in the WHO Eastern Mediterranean region. A thorough search of the literature resulted in 24 studies that were included in the synthesis. Mapping of study results generated four major areas of findings: including positive views and experiences (perceived adequate knowledge/ skills, positive attitude towards breaking bad news, received training, awareness of accepted approaches (e.g., SPIKES/ ABCDE), adherence to accepted approaches): negative views and experiences (reported lack of training, unaware of accepted approaches, lack of full disclosure to patients, unaware of institutional policy): practice varies with demographics; and experience, and need for education/training.

In the second phase, a qualitative study was performed to aimed to explore the related experiences of resident doctors three months after participating in the breaking bad news workshop. In terms of experiences of breaking bad news, the themes largely mirrored those of the scoping review. Three themes were mapped to the CIPP model in terms of aspects of the training workshop. The first of these related to context in terms of the assessment of training needs with interviewees acutely aware of their needs to foster skills development. The second training theme related to the actual workshop program, with interviewees particularly appreciative of the workshop in general and notably the emphasis on simulation, role-playing and real-life scenarios. The final theme related to the product domain of CIPP in terms of the post-workshop impact with

appreciation of the systematic approach to deliver bad news and that workshop was likely to have a long lasting impact on their abilities to deliver bad news.

4.2 Strengths and weaknesses

The strengths and weaknesses of the scoping review and the qualitative study are articulated in chapters 2 and 3 hence will not be repeated in this final chapter. One additional strength of the totality of the research is that taken together, the qualitative findings help to fill the gap identified in the scoping review where most studies had a quantitative, cross-sectional survey methodology. Both phases of the research have provided novel data and hence are an original contribution to knowledge, enhancing the evidence base.

4.3 Interpretation

The findings of this research offer significant and original insight into the views and experiences of health professionals in the WHO Eastern Mediterranean region regarding breaking bad news. One key aspect identified in the both scoping review and qualitative study was the linguistic and cultural barriers regarding breaking bad news. This aligns with the literature review by Khalil et al., which reported that major cross-cultural variations are present regarding breaking bad news in Western and non-western countries (Khalil, 2013). As medical education and practice have globalized in the last few decades, there is a need for health professionals to be equipped with the practice that is effective in every culture (Rukadikar et al., 2022). Therefore, there is a need for international students and medical institutions to incorporate breaking bad news skills, keeping in view cultural aspects and cultural competence. It is not unusual for health professionals to migrate to countries of different cultures to their own culture and those of the countries of their education. Several authors have highlighted the need for health professionals to understand cultural aspects and demonstrate cultural competence

(Sophie Nilusha & Jan, 2021). In Middle Eastern countries, diagnostic disclosure is routinely concealed in an attempt to save patients from the harm of bad news (Zekri & Karim, 2016). This is very different from Western countries where breaking bad news is a fundamental aspect of healthcare practice. This view is underpinned by the principles of autonomy, beneficence, and non-maleficence (Sophie Nilusha & Jan, 2021).

As breaking bad news is perceived differently in each culture, meeting the expectations of the patients and family members can be challenging for health professionals. In the present research in both scoping review and qualitative study, family-related challenges were reported as a significant concern while delivering bad news. Such practices may not be seen in Western countries as the family is not considered such a part of truth disclosure (Varkey, 2021). In the WHO Eastern Mediterranean Region, collective autonomy applies, therefore, patients may defer to their family members. In such a context, family members may force health professionals to conceal diagnoses to avoid damage to the patient's health. Disregarding cultural and family context can have an adverse impact on breaking bad news experiences of the patients and family members. A cross-sectional study from Pakistan reported that more than 80% of the patients preferred that their diagnosis was first revealed to their family members. Furthermore, they also reported that this behavior was influenced by the education level and income of the patients. An interesting finding was that patients who did not want to know their diagnosis stated God's will in doing so (Shah et al., 2023). This signifies that in region where the majority of the general population is religious, such factors should be kept in mind while breaking bad news to the patients.

Just like most countries in the WHO Eastern Mediterranean Region, Qatar has

diverse patient population and cadre of health professionals. Health professionals make up one of the largest expatriate communities in Qatar (Malik & Khan, 2020). This diversity poses both challenges and opportunities, making the incorporation of cultural aspects into healthcare delivery paramount. A study by Abdelrahim et al. provided detailed challenges that patients face while interacting with health professionals. Participants included in the study spoke Arabic, English, Hindi, and Urdu languages. Most participants reported that they faced barriers while communicating with health professionals. To counter these challenges, the participants adopted solutions such as utilizing incidental interpreters, piecing together fragments from different languages, and resorting to body language cues. They further reported that patients who did not speak Arabic and English, two main languages faced more challenges compared to others (Abdelrahim et al., 2017). Therefore, there is need for healthcare professionals to possess not only clinical expertise but also cultural competence while breaking bad news to patients from various backgrounds.

Similarly, the healthcare workforce in Qatar reflects this diversity, comprising professionals from numerous countries and cultural backgrounds. A study conducted in HMC and published in 2014 reported that laboratory personnel originated in 28 different nationalities, with Philippines accounting for 28%, followed by Indians (15%) and Qataris (14%) (Meqbel, 2014). In a study Bashir et al., which included health professionals from 10 nationalities in Qatar, the authors reported that social and cultural challenges, and Arabic language challenges were among five major themes identified in their study (Bashir, 2024). Amidst all these challenges, training workshops offer opportunities for the health professionals to develop communication skills, including breaking bad news. Health professionals involved in the workshop in this qualitative study reported that role playing scenarios were particularly useful in skills

development. Furthermore, they recognized the impact of the workshop in providing a more systematic approach to delivering bad news. As Qatar continues to evolve as a global hub for healthcare excellence, health professionals should be better equipped to handle patients from diverse background. Training workshops in Qatar and other countries in WHO Eastern Mediterranean Region are required to better equip health professionasl to meet the needs of diverse patient population.

4.4. Impact

The UK Research Councils categorise impact in terms of academic impact, and societal and economic impact as illustrated in Figure 2.

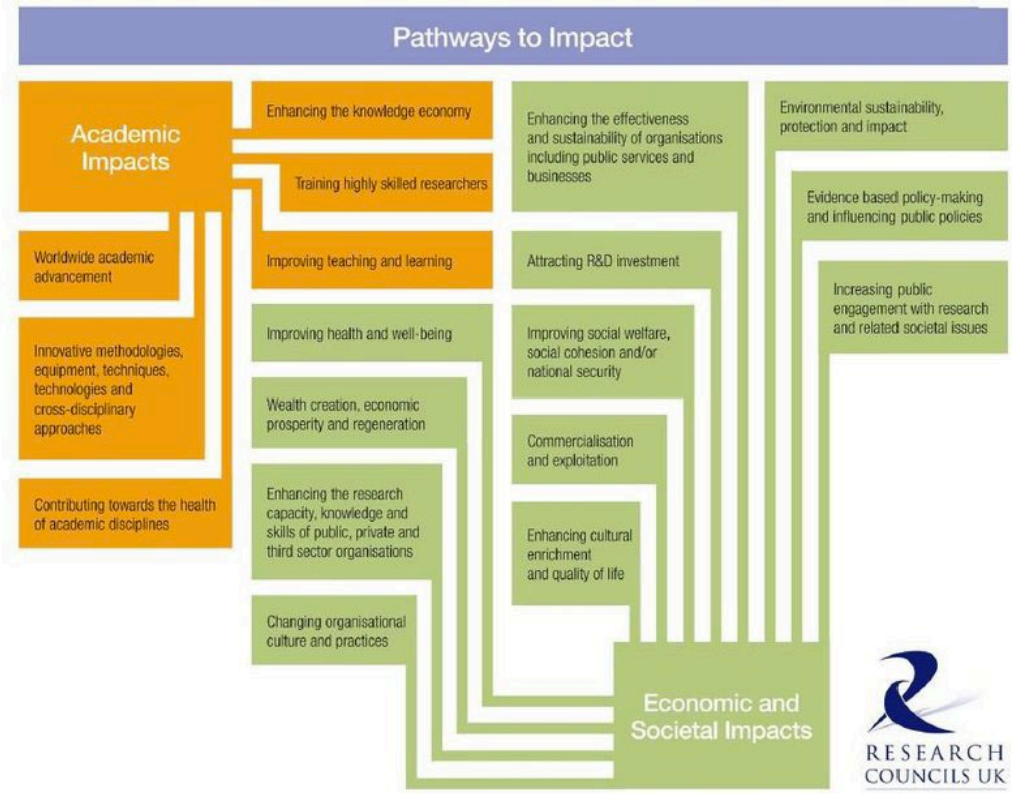

Figure 2. The UK Research Councils Pathways to Impact

In terms of this research study, the specific impacts are as follows:

4.4.1 Enhancing the Knowledge Economy

This research has contributed novel findings in relation to both the scoping review and the qualitative study. Of note, the scoping review highlighted a lack of qualitative

research conducted in the region in relation to breaking bad news.

4.4.2 Training highly skilled researchers

Conducting this study contributed to the skills development of the MSc student and provided an opportunity for reflection and professional development of the members of the supervisory committee.

4.4.3 Improving teaching and learning

The qualitative study in particular demonstrated the value of the workshop to those interviewed and gave an indication for future refinements and improvements. Incorporating cross-cultural aspects and language-related barriers in the workshops could further sensitize participants regarding this challenge.

4.4.4 Changing organizational culture and practices

The qualitative findings reinfornce the need for the workshop and provide an indication of the likely impact on practices, particularly employing a more systematic approach to breaking bad news.

4.5 Further research

The findings of this study also highlighted gaps in research. There is a need for future research to focus on the long term impact of participation in education and training relating to breaking bad news. While qualitative approaches are useful, more objective measures of success are required, which also incorporate definitions of 'success' from multiple perspectives.

While this research focused on the health professionals, there is a need for regional research which explores the experiences, perceptions, and needs of patients and their families when receiving bad news from health professionals. Such studies could also seek to understand the impact of receiving bad news on patients and their families. Qualitative approaches, such as semi-structured interviews or focus group

discussions, are best suited to allow indepth exploration of the issues, providing rich data for analysing gaps or areas for improvement in the delivery of bad news from their perspectives. Study participants should ideally be selected from diverse backgrounds and from various healthcare settings, including hospitals, clinics, and palliative care facilities, to capture a range of perspectives. There should also be emphasis on the cultural and language barriers faced by the participants when receiving bad news from health professionals.

4.6 Recommendations

Several key recommendations for practice can be derived from the present study.

- As noted above, there is a need for longer term impact research and qualitative research of health professionals and patients
- Systematic needs assessment relating to education and training in breaking bad news should be undertaken, accepting that breaking bad news is an essential skill for health professionals.
- Comprehensive education and training programs should be developed and implemented at all levels spanning undergraduate, postgraduate and professional development. These should focus not only on theoretical knowledge but also on practical skills development through simulation, role-playing, and real-life scenarios.
- Health professionals should also recognise and address cultural, linguistic, patient, and family issues that may present challenges in delivering bad news. Education and training programs should incorporate elements of cultural competency. Focus should also be placed on fostering empathy, building trust, and refining communication styles to ensure that bad news

is delivered in an appropriate and compassionate manner.

4.5 Conclusion

In conclusion, the findings of this scoping review and qualitative study conducted in the WHO Middle Eastern Region highlight that while health professionals report positive views and experiences of breaking bad news, many challenges persist in relation to breaking bad news, with extensive reporting of negative views and experiences. Focused workshops for early career professionals to meet expressed training needs, with emphasis on simulation, role-playing and real-life scenarios are likely to impact more systematic approaches with long term impact.

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APPENDIX A. TABLE CONTAINING RESULTS FROM ALL DATABASE SEARCH

Key variables	Sub terms	Search options	SCOPUS	Embase	CINAHL	Ebsco eBooks	ERIC via Embase
			Search Results (Date: 6 July 2023)	Search Results (Date: 6 July 2023)	Search Results (Date: 6 July 2023)	Search Results (Date: 6 July 2023)	Search Results (Date: 6 July 2023)
1. Breaking bad news	1.1 Bad news	All fields	127,727	3746	14703	2405	419
2. Health Professional	2.1 Health personnel	All fields	722,974	98439	156302	773	13800
	2.2 Health professional*	TI OR AB	264,184	89610	80845	3185	12642
	2.3 Healthcare professional*	TI OR AB	78,014	53830	50316	1947	3423
	2.4 Doctor*	TI OR AB	259,716	224738	74485	13978	16080
	2.5 Nurse*	TI OR AB	407,380	397401	407282	7895	10231
	2.6 Radiologist*	TI OR AB	83,270	99157	20691	427	54
	2.7 Pharmacist*	TI OR AB	68,590	90970	24149	1319	520
	2.8 Dentist*	TI OR AB	103,599	87477	24992	2230	1331
	2.9 Physiotherapist*	TI OR AB	15,971	21700	9919	444	93
	2.10 Dietitian*	TI OR AB	13,070	13172	6132	318	128
	2.11 Psychologist*	TI OR AB	61,104	31533	10445	6788	10590
	2.12 Laboratory technician*	TI OR AB	5,455	2283	453	257	425
	2.13 Physician*	TI OR AB	560,495	672207	174891	6213	5609
	2.14 Allied health	TI OR AB	16,134	15375	9053	624	1575
	2.15 Speech therapist*	TI OR AB	6,687	2307	1902	428	869
	2.16 Psychotherapist*	TI OR AB	9,932	6131	2366	1917	422
3. WHO Eastern Mediterranean Region	3.1 Middle East	Mesh (MH)			3378		
	3.2 Middle East	All fields	951,985	40648	129624	5846	7052
	3.3 Afghanistan	All fields	101,663	11852	17981	3342	691
	3.4 Bahrain	All fields	42,482	7986	3612	773	280

Key variables	Sub terms	Search options	SCOPUS	Embase	CINAHL	Ebsco eBooks	ERIC via Embase
			Search Results (Date: 6 July 2023)	Search Results (Date: 6 July 2023)	Search Results (Date: 6 July 2023)	Search Results (Date: 6 July 2023)	Search Results (Date: 6 July 2023)
	3.5 Djibouti	All fields	6,782	835	1258	401	18
	3.6 Egypt	All fields	740,758	207030	35680	5465	1680
	3.7 Iran	All fields	1,295,010	346954	107815	4169	4353
	3.8 Iraq	All fields	270,682	47723	23129	3805	921
	3.9 Jordan	All fields	1,610,702	101676	59618	5883	4490
	3.10 Kuwait	All fields	123,973	22448	8164	1484	675
	3.11 Lebanon	All fields	154,951	64942	23204	2156	951
	3.12 Libya	All fields	46,285	2569	2500	1591	203
	3.13 Morocco	All fields	249,984	43653	7888	2324	761
	3.14 Oman	All fields	163,755	16873	9479	1148	772
	3.15 Palestine	All fields	100,563	7153	4380	2429	716
	3.16 Qatar	All fields	93,121	27037	9625	983	470
	3.17 Saudi Arabia	All fields	604,310	175859	35278	2265	3076
	3.18 Somalia	All fields	32,202	3539	5199	1490	259
	3. 19 Sudan	All fields	177,386	22215	10250	2353	508
	3.20 Syria	All fields	82,044	4274	6161	2768	487
	3.21 Tunisia	All fields	233,288	65532	7508	1560	473
	3.22 United Arab Emirates	All fields	161,889	102580	9666	1019	1261
	3.23 Yemen	All fields	52,345	6743	4066	1217	224
1. Overall	1+2+3		2,905	61	437	1653	0

APPENDIX B. INTERVIEW SCHEDULE OF THE QUALITATIVE STUDY

Participants	**Schedule**
	September 2023:
P1	25/9
P2	27/9
	October 2023:
P3	11/10
P4	16/10
P5	25/10
	November 2023:
P6	6/11
P7	12/11
P8	27/11
	December 2023:
P9	13/12
P10	28/12

APPENDIX C. TABLE SHOWS THE CODES IDENTIFIED BY REVIEWERS

Reviewer 1	Reviewer 2	Reviewer 3	Reviewer 4	Reviewer
Codes				
Communication as a Core Skill	Communication skill	Key communication skill	Importance of BBN	Effectiveness of breaking bad news workshop
Empathy and Sympathy in Delivering Bad News	Potential benefits of bad news for patients	Impact on patient confidence and trust in provider	Implications of BBN	Communications skills-empathy, structured communication
Structured Approach to provide Clarity and ensure Empathy	Potential unintended consequence – mixed message/false hope	Benefit to all	Skill - Can be learnt	Time management, electronic documentation
Training Leads to Skill Development	Temporal component	Important attributes of provider	Characteristics of BBN	More practical exercises
Pre-workshop & post-workshop Practices	New learning/strategy – structuring interview	Negative impact of underplaying significance	What makes up a positive exp = Characteristics	Diverse patient reactions
Importance of Continuous Learning and Skill Reinforcement	Expected simulation Wanted clinical relevance	Pre-workshop, taking time	Impact of workshop - Awareness	Improving patient interactions, professional development
Social and Logistical Barriers to Effective Communication	Broader impact – underscores importance of communication	Importance to discuss WITH patients	Motivations towards enrollment	Need for training
Expectation of Simulation vs. Real-World relevance	Measuring improvement in communication skills	Pre-workshop. Not stepped, systematic approach	Mandatory - Job requirements - role requirement - Motivations	Time Management
Communication Beyond Patient Interactions	Empathy	Expectation of no impact as mandatory	Impact of workshop	Barriers to Communication
Workshop Impact on Personal Awareness of effective communicaiton	Value of workshop– transferable skill useful across many domains of medicine	Workshop exceeded expectations	Satisfaction level	Structured Communication Techniques

Importance of Environment and Timing	Barriers in breaking bad news - Social barriers	Positive long-lasting impact of workshop	Factors enhancing workshop experience	Electronic Documentation Challenges
Building Trust through Clear Communication	Honesty	Need for training reinforcement	Evaluation of health professionals by patients - factors affecting communication skills	Breaking Bad News
Preparation and Active Listening	Barrier – screens, documentation process	Need for patient input to evaluation	Impact - structured - becoming sym, emp, enhance self-efficacy in delivery of BBN, coherence, taking time	Effective Communication
Impact of Training	Impact – prioritizes face-to-face encounter, documents after encounter finished	Workshop impact of systematic approach	Improved interactions with other healthcare providers - impact of workshop	Empathy and Compassion
Expectations for Managing Emotions	Raises awareness/underscores importance of communication skills	Workshop impact, time spent with patient, reinforcement of message	Barriers: Scheduling, patient load, high turnover, lack of time, socially unpleasant experience	Patient and Family Impact
Workshop's Impact on Effective Communication Strategies	Process not just skill	Workshop impact on non-bad news communication, providers	Characteristics of BBN - sitting down, talk more, give them more time to process,	Trust in Healthcare
Role of Feedback in Refining Communication	Benefits – promotes trust, understanding, strengthen dr-patient relationship	Challenges, family	Communication	Emotional Distress
Continuous Learning and Professional Development	Adverse effects (if BBN not done well)	Challenges, time available	Impact on patients: Appreciative feedback, better understanding, more acceptance,	Communication Barriers
Role-Play in Enhancing Communication Skills	Adversst effects – emotional distress, confusion, undermines trust	Challenges, influence of setting	Barriers towards delivery - time constraints, computers, distractions, documentation, charting and looking at screens - or factors affecting delivery of BBN etc.	Roleplay Training

Strategies	Workshop impact, patient/family feedback	Characteristics: repertoire with patient and family, understanding diversity of patients and their psychology	Emotional and Informational Support
Simulation - valuable	Challenges, perceived impact on patient care		Communication Skill Development
Skill development – compassionate communication	Challenges, environment, documentation process		Patient-Centered Approach
Effective listening	Need for further training		Nonverbal Cues
Impact – developed awareness of broader impact of words/action	Importance of how done, consider impact on patient		Professional Development
Impact – no longer focus on disability info but focuses on support and checking for understanding	Trust development		Sustainable Communication Practices
Challenge – takes time to master	Benefit, trust and understanding, patient and family		Roleplay and Real-Life Scenarios
Skills development: Empathy, communication	Benefit, provider patient relationship		
Process: importance of preparation, mentally prepared for encounter	Benefit, perception of enhanced care		

Benefit: takes patient perspective into account; being present	Negative impact, distress, confusion
Benefit: become patient-centered	Negative, loss of trust - provider, system
Challenges: consistency in practice, staff turnover, diverse pt population	Before workshop, need for preparation
Challenges: can’t be one off, need multiple and repeated CPD attempts to master skills	Expectations met
Simulation: role play using real life scenarios	Workshop, challenging situations
	Workshop impact, tailoring message, compassion
	Workshop impact, empathy, active listening, emotion
	Workshop impact, evolved practice
	Workshop impact, reflection, support provided

Workshop impact, own emotions

Workshop impact, feedback providers, patients, families

Need for continued practice

Need for practice, reflection

Workshop impact, need for preparation, patient perspective, deep involvement

Workshop impact, patient centred

Workshop impact, non-verbal cues, holistic approach

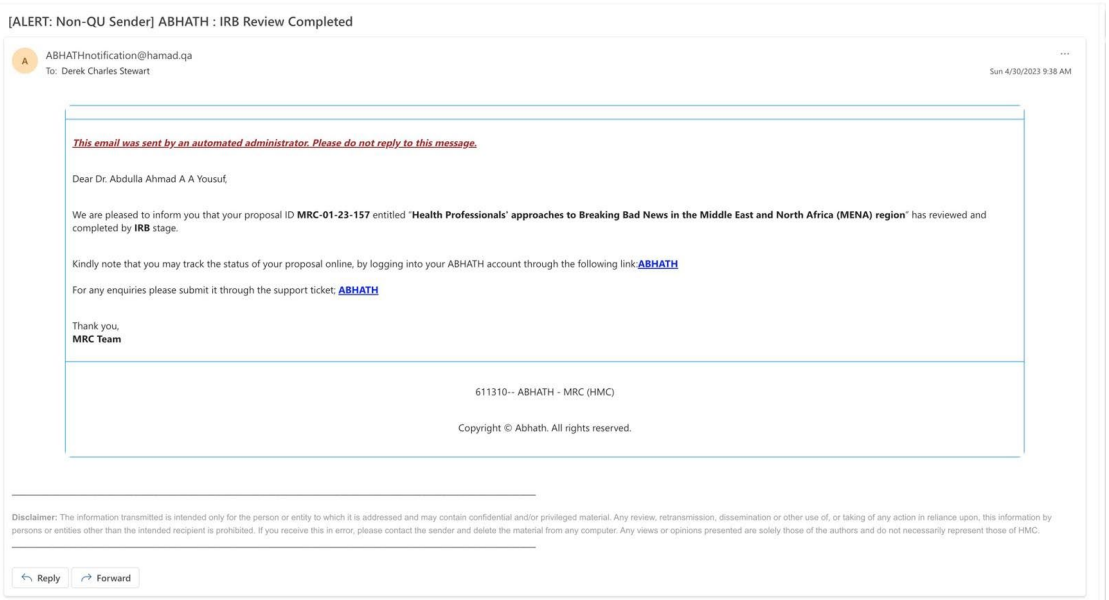
Workshop - importance of role play

Sr.	Framework
1	Benefits of breaking bad news
2	Role of communication
3	Empathy
4	Training - Need for training, impact of training
5	Impact of workshop
6	Pre-workshop & post-workshop Practices
7	Workshop impact on non-bad news communication
8	Workshop impact of systematic approach
9	Workshop impact, time spent with patient, reinforcement of message
10	Positive long-lasting impact of workshop
11	Challenges, family
12	Challenges, time available
13	Challenges, influence of setting
14	Challenges, perceived impact on patient care
15	Challenges, environment, documentation process
16	Roleplay and Real-Life Scenarios
17	Expectation of Simulation vs. Real-World relevance
18	Trust development
19	Adverse/Negative impact of breaking bad news

This was further reduced to

Sr.	Framework
1	Benefits of breaking bad news
19	Adverse/Negative impact of breaking bad news
2, 3, 18	Communication, empathy, trust
4	Training – Expressed need for training
6	Pre-workshop practices, general
8	Workshop impact of systematic approach
9	Workshop impact, time spent with patient, reinforcement of message
10	Positive long-lasting impact of workshop
11, 14	Challenges, patient, family
12, 13, 15	Challenges, resource (time available, documentation, setting)
16, 17	Workshop experiences simulation, roleplay, real-life scenarios

APPENDIX D. ETHICAL APPROVAL FROM HMC



[ALERT: Non-QU Sender] ABHATH : IRB Review Completed

ABHATHnotification@hamad.qa
To: Derek Charles Stewart
Sun 4/30/2023 9:38 AM

This email was sent by an automated administrator. Please do not reply to this message.

Dear Dr. Abdulla Ahmad A A Yousuf,

We are pleased to inform you that your proposal ID **MRC-01-23-157** entitled "**Health Professionals' approaches to Breaking Bad News in the Middle East and North Africa (MENA) region**" has reviewed and completed by **IRB** stage.

Kindly note that you may track the status of your proposal online, by logging into your ABHATH account through the following link:**ABHATH**

For any enquiries please submit it through the support ticket; **ABHATH**

Thank you,
MRC Team

611310-- ABHATH - MRC (HMC)

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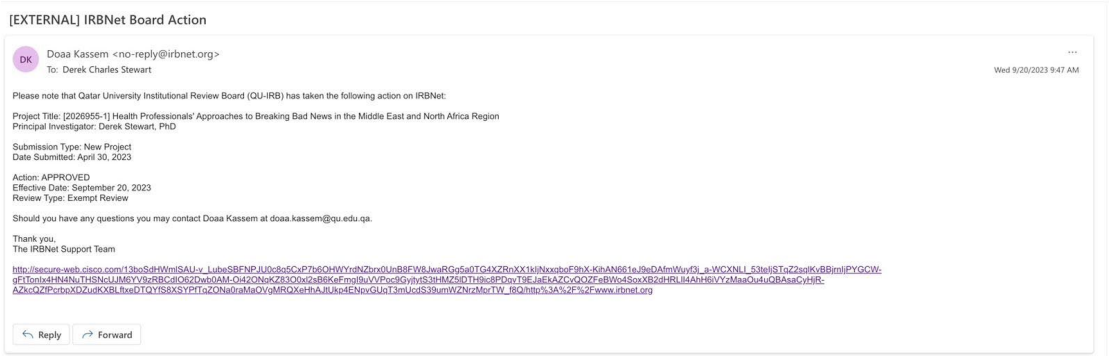
Reply Forward

APPENDIX E. ETHICAL APPROVAL FROM QATAR UNIVERSITY



[EXTERNAL] IRBNet Board Action

Doaa Kassem <no-reply@irbnet.org>
To: Derek Charles Stewart
Wed 9/20/2023 9:47 AM

Please note that Qatar University Institutional Review Board (QU-IRB) has taken the following action on IRBNet:

Project Title: [2026955-1] Health Professionals' Approaches to Breaking Bad News in the Middle East and North Africa Region
Principal Investigator: Derek Stewart, PhD

Submission Type: New Project
Date Submitted: April 30, 2023

Action: APPROVED
Effective Date: September 20, 2023
Review Type: Exempt Review

Should you have any questions you may contact Doaa Kassem at doaa.kassem@qu.edu.qa.

Thank you,
The IRBNet Support Team

http://secure-web.cisco.com/13boSdHWmlSAU-v_LubeSBFNPJU0c8q5CxP7b6OHWYrdNZbrx0UnB8FW8JwaRGg5a0TG4XZRnXX1kIjNxxqboF9hX-KihAN661eJ9eDAfmWuyf3j_a-WCXNLL_53teljSTqZ2sqlKvBBjrnljPYGCW-gFtTonlx4HN4NuTHSNcUJM6YV9zRBCdlO62Dwb0AM-Oi42ONqKZ83O0xi2sB6KeFmgl9uVVPoc9GyjtytS3tHMZ5lDTH9ic8PDqvT9EJaEkAZCvQOZFeBWo4SoxXB2dHRLlI4AhH6iVYzMaaOu4uQBAsaCyHjR-AZkcQZfPcrbpXDZudKXBLftxeDTQYfS8XSYPfTqZONa0raMaOVgMRQXeHhAJtUkp4ENpvGUqT3mUcdS39umWZNrzMorTW_f8Q/http%3A%2F%2Fwww.irbnet.org

Reply Forward

APPENDIX F. CONSENT FORM PRIOR TO THE INTERVIEW

مؤسسة حمد الطبية
Hamad Medical Corporation
HEALTH • EDUCATION • RESEARCH صحة • تعليم • بحوث

1. Title of research

Health Professionals' Approaches to Breaking Bad News in the Middle East and North Africa (MENA) region

2. Principal Investigator

-

3. Why are we inviting you to join this research?

The investigator and colleagues at Hamad Medical Corporation (HMC) and Qatar University (QU) are inviting you to participate in this research because you are a resident doctor at HMC and have enrolled in a workshop on Breaking Bad News.

4. What should you know about this research?

- We will explain the research to you.
- The aim of the research is to explore breaking bad news from healthcare professionals' perspectives in the Middle East and North Africa (MENA) region.
- Whether or not you join is your decision (you can accept or refuse, no matter who invites you to participate).
- Please feel free to ask questions or mention concerns before deciding, during, or after the research.
- You can say yes but change your mind later.
- We will not hold your decision against you.

5. Who can you talk to?

If you have questions or concerns, or if you think the research has hurt you, talk to the research team at:
Dr. Abdulla Yousuf
Email: Ayousuf@hamad.qa
Mobile: +974-55865999

If you have questions about your rights as a volunteer, or you want to talk to someone outside the research team, please contact:

- HMC Institutional Review Board (HMC-IRB) Chair at 5554 6316

- HMC-IRB Office at 4025 6410 (from Sunday to Thursday between 7:00 am-3:00 pm) or email at irb@hamad.qa

6. Why are we doing the research?

Breaking bad news is integral to medical practice. Every doctor has to break bad news at some point during their practice. Suitable delivery of bad news can have positive consequences; however, if bad news is not delivered competently, it can adversely impact patient outcomes and have negative consequences for the health professional.

As part of its Continuing Professional Development training, HMC delivers workshops on Breaking Bad News and you have enrolled on one of these. We are exploring residents' experiences of breaking bad news before and after training to evaluate the impact of these workshops.
The results of the research will allow us to reflect on, and improve the training.

7. How long will the research take?

We expect the research will involve a pre and post training interview. Each interview will take approximately 45 mins. We expect the study to last for 3 months.

8. How many people will take part?

Approximately fifteen participants will participate in the study.

9. What happens if you take part?

You will be interviewed approximately one month before attending the training. This interview will last around 45 minutes and will be conducted via Microsoft Teams. The interview will be recorded and then transcribed. You will not be identified personally on the transcript or any report or publication.

You will then be interviewed using the same approach around three months after completing the training.

10. Could the research be bad for you?

This is an observational study and the risk of participation is considered minimal. We are going to be asking questions about your experiences of breaking bad news to patients. You may skip any questions that you are uncomfortable answering.

The research team has taken steps to protect your information from a breach of confidentiality. These measures are described below.

11. Could the research be good for you?

Taking part in this study may not benefit you directly, but researchers and trainers may learn new things that will help improve the Breaking Bad news training.

12. What happens to information about you?

We will make efforts to secure information about you. This includes using a code to identify you in our records instead of using your name. We will not identify you personally in any reports or publications about this research. We cannot guarantee complete secrecy, but we will limit access to information about you. Only people who need to review information will have access. These people might include:

• Members of the research team whose work is related to the research or to protecting your rights and safety.

• Representatives of the Ministry of Public Health Qatar and HMC Medical Research Centre who ensure the study is done appropriately and that your rights and safety are protected.

We plan to use data collected from this study in future projects, including sharing the data with other researchers. Although we will keep a link between your identity and the data about you, we will not provide that link to anyone we share the data with.

13. What if you don't want to join?

Taking part is voluntary. You can decline and we will not hold it against you. This will not affect your participation in the training.

14. What if you join but change your mind?

If you decide to take part but later change your mind, you may opt out at any time If you are uncertain about participating or would like any clarification on the research study before you conduct the interview(s), please feel free to ask any questions.

15. What else should you know?

If you are injured directly due to research procedures, contact the Investigator, and appropriate care will be available at HMC. If you seek care outside of HMC, such care will be at your expense. Compensation is not available in case of injury. The Investigator or sponsor may stop the study or take you out of the study at any time, even if you would like to continue. This could happen because investigators consider your continuation in the study unsafe, a severe adverse event occurs while receiving the treatment, or an exclusion criterion was discovered later.

16. Additional Choices

You might need to provide your contact details (email, mobile no). Further, demographic details such as age, gender, speciality, and workplace might be obtained during the course of the study.

We would like your permission to contact you about participating in future studies. You may still join this study even if you do not permit future contact. You may also change your mind about this choice.

Please initial your choice below:

_____YES, you may contact me

_____NO, you may NOT contact me