

Announcement of a Cancer Diagnosis

Hanène Ben Salah^{1*}, Jihen Aloulou² and Jamel Daoud¹

¹Radiotherapy Department, Habib Bourguiba's Hospital, Sfax University, Tunisia

²Psychiatry Department, Hedi Chaker's Hospital, Sfax University, Tunisia

***Corresponding Author:** Hanène Ben Salah, Professor, Radiotherapy Department, Habib Bourguiba's Hospital, Sfax University, Tunisia.

Received: April 06, 2020; **Published:** August 31, 2020

Abstract

Objective: To explore the knowledge and experiences of senior physicians and study the impact of their training on practice in the area of cancer diagnosis reporting.

Methods: A questionnaire was sent by email to the doctors who are faced with the announcement of the diagnosis of cancer in our 2 teaching hospitals in Sfax, Tunisia.

Results: 79 doctors participated in the study. One or more training courses were attended by 53 physicians. Of the 79 physicians, 46.2% were unaware of the steps in announcing the diagnosis of cancer. The different steps of the announcement were better practiced by doctors who had training in communication, health simulation and or role playing.

Conclusion: There are shortcomings in both knowledge and practice in announcing the diagnosis of cancer.

Keywords: Cancer Diagnosis; Knowledge; Experiences; Senior Physicians

Introduction

The announcement of bad news, particularly of cancer diagnosis, radically and negatively changes the patient's conception of his future [1,2]. All doctors are confronted with this type of announcement during their practice [2]. In oncology, the announcement of bad news may relate to an initial diagnosis of cancer, a relapse, a therapeutic failure, the course of the disease, or referral to palliative care. The meaning that the patient will give to the announcement as well as his reactions will be determined by many variables, including: socio-demographic, environmental, psychosocial but also contextual factors (place of announcement, presence of a close, attitude of the practitioner) [1,3-6]. If the announcement of bad news in oncology is commonly defined from the patient's point of view, to ignore the practitioner in the definition of this concept would be nonsense. Indeed, it appears first in the temporal dynamic that constitutes the announcement. He is the first of the two protagonists of the announcement to be aware of it, to take a look at the announcement, to assess it and to describe it as good or bad news [2]. Likewise, announcing bad news in oncology is a matter of communication skills which constitute a pillar of care. As such, it must meet three fundamental objectives: create a quality interpersonal relationship, exchange information and make a therapeutic decision [3-5]. However important as it is, training in the relational and communicational register remains at the initiative of academic institutions and data on the experience of doctors concerning this situation are limited. However, training in interview management in the event of a serious diagnosis such as cancer is not a bit extra, but a real challenge for both patients and doctors. It requires learning using active methods such as role playing simulation [7,8].

Objective of the Study

The objectives of this work were to explore the knowledge and experience of a population of doctors practicing in the two teaching hospitals in Sfax (Tunisia) and to study the impact of their training on their practices in the field of announcement of cancer diagnosis.

Methods

This is a descriptive cross-sectional study involving university doctors and specialists from 2 university hospitals Habib Bourguiba and Hédi Chaker in Sfax (Tunisia).

We included in our study physicians practicing in medical and surgical specialties where the announcement of a diagnosis of cancer can be part of their activities.

We did not include residents and interns estimated to be still in training and physicians who are very rarely confronted with the announcement of a cancer diagnosis.

We established a questionnaire on the basis of the data available in the literature on the knowledge necessary to acquire the skills for announcing bad news and on the theoretical steps of this announcement. This questionnaire consisted of 34 items exploring knowledge and studying practices in the area of the announcement of the diagnosis of cancer in order to analyze the situation (Annex 1). An invitation to fill in a questionnaire was created and sent by email to "Google forms". The questionnaire was sent to 120 doctors. Responses were recorded on Google forms. The questionnaires entered online were analyzed using Excel software. The data were described by percentages for the qualitative variables and by means with their standard deviations for the quantitative variables.

Results

Of the senior physicians who received the questionnaire, 79 participated in the study (65.8%).

No training dedicated to announcing the diagnosis of cancer was followed for 32.9% of doctors. The rest have had one or more trainings (Table 1). All doctors were confronted with the announcement of the diagnosis of cancer. They were faced with the diagnosis of cancer frequently in 43% of cases, often in 44.3% of cases and rarely in 12.7% of cases. Among the 79 doctors, 46.2% said that they did not know the steps of the announcement of the cancer diagnosis.

Trainings	Number	Percentage
Communication only	11	13.92 %
Communication + role playing	10	12.65 %
Communication + role playing + simulation	7	8.86 %
Role playing only	14	17.72 %
Role playing + oncopsychology	1	1.26 %
Role playing + health simulation	6	7.59 %
Health simulation only	4	5.06 %

Table 1: Distribution of doctors according to training received.

The pre-announcement

1. Study of tumor pathology: In 88.6% of cases, doctors expressed the need to learn about tumor pathology before announcing the diagnosis of cancer.

2. Doctors' willingness to make the announcement of a cancer diagnosis: They often do not want to make this announcement themselves (62%).
3. Scheduling of appointments: Consultation was only planned in 39.2% of cases.
4. The possibilities of providing a reasonable time for the announcement: 98.9% of doctors could have provided a reasonable time. This reasonable time was 30 minutes for 68.4% of the doctors.
5. Preparing the environment for a cancer diagnosis announcement: Doctors were unable to prepare the environment for the announcement in 54.4% of cases.
6. Patient preparation for the announcement: It was possible for 68.4% of doctors.
7. Choosing the right time for the announcement: It was possible for 57% of doctors.
8. The patient's experience before the announcement of a cancer diagnosis: Doctors questioned the patient about his experience before the announcement in 73.4% of the cases.
9. Taking into account what the patient wants to know: This was done in 82.1% of cases.
10. Taking into account what the patient knows about his state of health: This was done in 97.5%.
11. Accompanying person and announcement of cancer diagnosis: The presence of an accompanying person was essential for 46.7% of doctors. He is identified in 87% of cases. A third of the doctors announced the companions, not the patient.

The announcement

1. Choice of terms: During the announcement, 30.4% of the doctors had difficulty finding a simple and accessible vocabulary for the patient. The use of Arabic terms was recognized as recommended by 87.3% of physicians.
2. Graduate the information according to the patient: The announcement was made in 1 consultation in 44.3% of cases.
3. Exploring the patient's emotions during the announcement: The doctors felt able to explore the patient's emotions in 73.4% of the cases.
4. Content of the advertisement: In a curative situation: 51.9% of doctors often informed their patients of the prognosis of the disease. The explanation of the therapeutic possibilities was always made for 64.6% of the doctors. Survival rates were often given according to 39.2% of the doctors. In a palliative situation: 55.7% of doctors rarely informed their patients of the cancer prognosis and 16.5% did not. The therapeutic possibilities are often explained to the patient according to 44.3% of the doctors. Survival rates were not communicated to patients in palliative situation, according to 60.8% of doctors.
5. Verification of the patient's understanding: It was done for 81% of the doctors. However, 34.2% of doctors thought that it was another trauma to avoid.

The post announcement

1. Keep hope alive: In a curative situation, 72.5% of doctors always gave hope to their patients, while 26.6% of doctors did it often and 1.2% did not. In a palliative situation, doctors often kept hope for their patients in 46.8% of cases, 19% always did.
2. Allow time to answer the patient's questions: 92.4% planned this time.
3. Emotional support to the patient: They estimated to do so in 55.7% of cases.
4. Request for help from the psychiatrist: Rarely made in 70.9% of cases.

Impact of doctor's training on the practice of announcing the diagnosis of cancer

By comparing the group of doctors who have had no training to that of doctors who have had one or more training, we can see that:

- 66% of them recognized the steps of the announcement (versus 27%). Among physicians having undergone simulation training in health, this rate was 82.3%.
- The study of tumor pathology before the announcement: Was made in more than 88% of cases and in 100% of doctors who had training in simulation.
- 92.3% of untrained doctors planned a reasonable time for the announcement (estimated at 30 minutes) and 88.6% of them in the absence of training in this area.
- The preparation of the patient for the announcement was possible in 73% of the cases in the absence of training and in 82% of the cases for the doctors having had a training in communication.
- The choice of the appropriate time for the announcement of the diagnosis of cancer was made by 54.7% of the doctors trained versus 61.53% of the doctors not trained in this field.
- Before the announcement, 65% of untrained doctors explored the patient's experience versus 77.35% of those trained in the area of cancer diagnosis announcements.
- 73% of untrained doctors and 85% of patients who received training in the area of cancer diagnosis were taken into consideration.
- All the doctors took into account what the patient knew about his state of health regardless of their training.
- During the announcement, a third of the doctors had difficulty finding a vocabulary accessible to the patient. For doctors trained in health simulation, role playing and communication; these difficulties were reported in 14.28%. Over 84% of doctors knew that the use of Arabic terms was recommended.
- Doctors who had received role-playing training were those who rarely announced the diagnosis of cancer to an attendant and not to the patient (28.5%).
- Multiple consultations were necessary for the announcement for 53% of the untrained doctors and 28.5% of the doctors who had 3 trainings.
- Information on the treatment was given to the patient in 100% of the cases in a curative situation. In a palliative situation, the patient was informed of his treatment in 53.8% of untrained doctors and in 71.7% of those who had training in the field of advertising.
- Information on prognosis of the disease was given to patients in a curative situation for 95% of the doctors. In a palliative situation, information on the prognosis was given by 30.7% and 26.4% untrained and trained doctors respectively. Only 14.29% of doctors who had had three courses communicated information on the prognosis in palliative situations.

In a curative situation, all the doctors gave hope to the patients while 2/3 of them did so in a palliative situation. Doctors who had three trainings always gave hope to the patient regardless of the situation.

Doctors who had three training sessions (in simulation, role playing and communication) were the most capable of exploring the patient's emotions (85%) than those who had training or those who were not trained.

In post announcements the doctors having had 3 trainings planned a time to answer the questions of the patients in 100% of the cases whereas the other untrained doctors did it less frequently (88,46%).

Doctors who were able to always provide emotional support to the patient represented 57.7% of untrained doctors and 54.7 of those who had one or more training. Of the physicians trained in communication, 82% believed that they were able to always provide emotional support to their patients.

Table 2 summarizes the differences observed between trained and untrained physicians in the area of cancer diagnosis.

Items	No training (26)	One or more Trainings (53)
Knowledge of the steps of the announcement	27 %	66%
Announcement scheduling	92%	37,7 %
Possibility to allow reasonable time	92,3%	88,6%
Reasonable time of 30 mins	77%	64%
Préparation de l'environnement	53,8%	54,7%
Environmental preparation	73%	66%
Choosing the right time	61%	54%
Explore the patient's experience	65,3%	77,3%
Take into account the patient's wishes	73%	84,9%
Announce in multiple consultations.	53,8%	56,6%
Difficulty finding vocabulary accessible to the patient	34,6%	28,3%
Recognize the recommendation of the Arabic language	84,66%	88%
Inform about curative treatment	100%	98,12%
Inform about palliative treatment	53,84%	71,7%
Announce the prognosis in a curative situation	96%	94%
Announce the prognosis in a palliative situation	30,77%	26,43%
Announce survival in a curative situation	46%	43,41%
Do not talk about survival in a palliative situation	96%	92,46%
Explore the patient's emotions	91,2%	75%
Giving hope in a healing situation	96%	100%
Giving hope in a palliative situation	65,39%	66%
Allow time to answer patient questions	88,4%	92,4%
Emotional support	57,7%	54,7%

Table 2: Differences between trained and non-trained doctors for the different stages of the cancer diagnosis announcement (better in fat).

Discussion

The literature offers recommendations for the announcement of bad news [9-14]. Based on these recommendations, a model has been constructed of reporting bad news as a three-phase process that is closely related (pre-announcement, announcement, post-announcement) [15]. This process includes the six steps in the "SPIKES" bad news diagnostic announcement [10-14] which are:

- S: "Setting up the interview".
- P: "Assessing the Patient's Perception".
- I: "Invitation from patient to give information".
- K: "Knowledge-explaining medical facts".
- E: "Explore emotions and empathize as patient responds".
- S: "Strategy and summary".

In our series, 46.2% of physicians were unaware of the steps involved in announcing bad news. Among the doctors who had at least one training, a third did not know it. This could be linked to the content of these training courses and especially to the targeted objectives aiming at interpersonal skills, more than know-how.

The pre-announcement

It is devoted to preparing the patient for the announcement and assessment of the situation. It also requires a doctor's preparation. Indeed, the announcement of cancer involves a long and specific consultation, dedicated to the announcement of the confirmed diagnosis. The doctor must allow a reasonable time for the announcement of 15 to 30 minutes [15,16].

In our study, it was possible to predict a reasonable time for 98.9% of physicians, although the consultation was only planned in 39.2% of cases. Reasonable time was estimated at 30 minutes for 68.4% of the doctors.

Before the interview, the doctor must review the information available on the pathology. This is the case for 88.6% of our doctors. The doctor must also prepare the patient for the announcement and choose the right time. Bad news is coming, the patient must see it coming [9,17].

Patient preparation for the announcement was possible for 68.4% of the physicians participating in our study. During the pre-announcement phase, the doctor must represent the cognitive and emotional state of the patient, trying to understand what the patient already knows, what he wants to know and his emotional state [15,18,19].

The patients' wishes were taken into account in 82.1% of cases in our study. Our doctors took into account what the patient knew about their medical condition before making the announcement in 100% of cases (with or without training).

The doctor must certainly adjust to what the patient is ready to hear, while taking into account medical needs [15,18,19]. It is the same for the patient's companion if he is present during the consultation [15,18,19]. In fact, in Muslim countries, the disease is a family event. The family often occupies the first rank, often wishing all to know about the disease and its treatments and not to transmit "worrying" information to the patient. It participates in the therapeutic decision [19,20]. A third of our doctors (34.2%) made the announcement only to the companion, not the patient.

During the announcement

The doctor must know, what to say, how to say, how to handle the series of emotions that accompany the announcement and also how to manage his own emotions during the interview [9]. The bad news must be announced precisely (clearly name the disease). Avoid using medical terms, which is overly recommended for 87.3% of doctors. The doctor must measure the information and proceed step by step, paying attention to the patient's response, knowing that 80% of the communication is in "the non-verbal" [9,14,15]. This helps prevent the patient from being overwhelmed by a flood of information that they are unable to process at the same time [9,14,15]. The diagnosis of cancer was announced gradually, in several consultations in 55.7% of the cases in our study.

From an ethical point of view, the doctor cannot position himself facing the patient, taking into account only his desire for information. Its role goes far beyond a simple obligation to inform. He must constantly juggle between the "said" and the "unsaid" [9]. This is particularly recommended in the case of palliative care [1,14,16,17]. In a curative situation, the doctors in our series often informed their patients of the prognosis of the disease in 51.9% of cases, while 1.3% did not. The therapeutic possibilities are always explained to the patient for 64.6% of the doctors. Survival figures were often given to the patient in 39.2% of cases. In palliative situations 55.7% of our doctors rarely informed their patients of the cancer prognosis and 16.5% did not do so at all. The therapeutic possibilities in palliative situation, are often explained to the patient in 44.3% of cases. Survival rates were not communicated to palliative patients in 60.8% of cases.

This choice made by our doctors not to communicate certain information is justified for certain authors who propose 3 methods to communicate bad information, full disclosure, non-disclosure and individual disclosure [12,18-20]. Individual disclosure would be the ideal method which takes into account the difference between patients (culture, age, cognitive abilities, social level, family relationships...) and barriers to communication (language, accents, environment, pain...), but requires learning [12,21,22].

A diagnosis of cancer is always followed by shock and suffering, which may or may not be expressed [9,23]. The word cancer, in our imagination, represents this slow death, in pain and in degradation [9,23]. As a doctor, we must show humanity, simplicity and empathy [23]. One of the quality criteria of the cancer diagnosis announcement is to observe the patient's reactions, to allow rests so that he can integrate the information. The doctor must analyze the emotional aspects of the patient's reaction (the emotions) as well as the cognitive aspects of the reaction [9,23].

Most of the time, healthcare professionals are afraid to explore the suffering of their patients for fear that it will affect them. However, experience shows that by working on the anxiety of their patients, doctors themselves find more comfort [9,23,24]. In our study, doctors felt able to explore the patient's emotions in 73.4% of the cases. Untrained physicians believed they were able to explore the patient's emotions in 96.23% of cases while trained physicians were aware of the difficulty in exploring the patient's emotions and believed that they were able to explore it in 75.47% of cases.

During the announcement phase, the main communication tool will be the transmission of information that will allow the announcement to be understood by the patient and their family [15,25]. The doctor must check the patient's understanding and correct cognitive errors [14-16]. One of the skills of the doctor in this phase is to remember that what is important is what the patient hears and understands, not what is said [14-16]. For 81% of the doctors of our series the patient's understanding during the announcement must be checked. However, 34.2% of doctors thought that checking understanding is a new double trauma (both for the doctor and for the patient), which should be avoided.

In post-announcement

During this phase the doctor must respond to the patient's reactions, keeping the hope alive. He checks what the patient is remembering through discussions and agreements while looking for any outstanding questions. Thus, the doctor will provide informational and emotional support to the patient and his family [4,5,15]. In a curative situation, all of our doctors gave hope to patients while 2/3 of them did so in a palliative situation. Doctors who had three courses (in simulation, role playing and communication) always gave hope to the patient whatever the situation.

Doctors who had 3 courses planned a time to answer questions from patients in 100% of cases, while other untrained doctors did so less frequently (88.46%). Physicians who were able to always provide emotional support to the patient represented 57.7% of untrained physicians and 54.7 of those with one or more training. Of the physicians trained in communication, 82% believed that they were able to always provide emotional support to their patients.

Psychological support is sometimes essential [25,26]. The announcement of the diagnosis most often results in a shock reaction in the patient. He is in a state of amazement: his psychic mechanisms are blocked, paralyzed, making the intervention of a psychologist often questionable. This intervention will allow the patient to reclaim the content of the consultation already carried out, to ask the important questions in his eyes and to discuss his future [26]. In our relevant departments of the two CHUs we do not have a nurse accompanying the diagnosis of cancer or a psychologist.

Impact of the training of doctors on the announcement on their practices

Several studies have shown a lack of good-quality education about spreading bad news in undergraduate medical courses and for first-time physicians. Several factors negatively influence their performance in communicating bad news such as a lack of communication skills, their own fear, lack of support from their supervisors and time constraints [27].

Seventy percent of doctors rarely referred psychiatric patients.

In our series, 53 doctors had one or more training. Training in health simulation was attended by 17 doctors (21.5%). Those who received role-playing training represented 48% and 35.4% of physicians received training in communication.

Communication and bad news training is necessary and effective. A study has shown their impact on the duration of the phases of the announcement process, the communication strategies used, the inclusion of the family in the announcement consultation and the physiological activation of doctors. These results undoubtedly plead in favor of intensive training in communication and the dissemination of bad news intended for health professionals [15]. In our series, doctors trained in communication were better for the items "Patient preparation for announcement" and "emotional support".

It therefore seems that the "information of medical facts" and "exploration of emotions" remains difficult after a theoretical teaching of communication. This was reported by Cutinho F [27]. Experienced clinicians and researchers in the fields of medical education and communication stress the central and compulsory role of doctor-patient communication during the clinical process to ensure the success of diagnostic and treatment strategies. The work of recent decades has made it possible to identify the key factors in the teaching and learning of effective professional communication in the health field [28].

In an effort to identify the effects of an oncologist training program in communication, 30 oncologists were randomly assigned to either an intervention or control group. Participants were assessed on their communication performance during the simulated consultation and their confidence in communication with patients at the start and during follow-up [29]. A total of 1192 patients were assessed for their distress and satisfaction with the consultation and their confidence in their oncologist after the consultation. The performance scores of the oncologists in the intervention group were considerably improved, in terms of emotional support, the creation of a favorable environment and their ability to deliver information. During the follow-up these oncologists had more confidence in themselves. Patients who met oncologists after having had communication training were significantly less depressed than those who met oncologists in the control group [29].

In our study, the doctors trained in simulation, role-playing and communication were the best at satisfying the following items:

- Little difficulty in finding a simple and accessible vocabulary.
- Give hope to the patient.
- Explore the patient's emotions.
- Allow time to answer the patient's questions.
- Doctors who were not trained in the announcement, however, were more careful in planning more announcement consultations and in spending more time on the announcement with a timely choice of the announcement time.

One study tested the effectiveness of a brief training module in announcing bad news using structured objective clinical assessment (OSCE) measures [30]. This randomized study (N = 66) compared the intervention and control groups of students (n = 28) and residents (n = 38). The authors concluded that this training module is an effective method for improving bad news communication skills among medical students and residents and that the implementation of this brief individualized training module as part of Health education could improve communication skills and care [30].

A meta-analysis reviewed qualitative studies of the experiences and views of oncologists regarding the announcement of bad news in adult oncology. Data was collected through an interview, focus group, observation or various combinations. The main circumstances of the announcement of bad news (initial diagnosis, relapse, palliative care, end of life) were represented [31]. It has been found that oncologists must necessarily and constantly adapt to each situation, especially when the news is bad. They also need to tailor communication to both

the patient and the family. The culture of the patient but also of the oncologist strongly influences the way bad news is given and received. Specific education programs should be devoted to this area [31].

Research evidence suggests that communication skills are not necessarily improved reliably with experience [32]. In our study, physicians who had no training dedicated to reporting bad news were the best to schedule an announcement consultation. But they were in second place in the different steps of the announcement, although they expressed an ability to explore the patient's emotions.

Considerable effort is therefore devoted to training that can improve communication skills or "communication skill training (CST)" for health professionals (PS) involved in oncology care [32].

A literature review with a meta-analysis was carried out to determine if the CST is effective in terms of improving communication skills and patient satisfaction and which types of CST, if any, are most effective [32]. This meta-analysis included randomized studies (with a control arm) evaluating "CST" versus no intervention among healthcare professionals in oncology. The main objectives were changes in communication skills with real and/or simulated patients [32]. Health professionals in the CST group were statistically more likely to use open-ended questions in "post-intervention" interviews than the control group, and more likely to show empathy for patients [32]. There were no statistically significant differences in other communication skills, except for the subgroup of participant interviews with simulated patients, where the intervention group was significantly less likely to present "facts only" by compared to the control group.

The Limits of Our Study

- Recruitment bias: Only 120 doctors received the questionnaire due to invalid email addresses.
- Self-selection bias: Doctors who agreed to participate in the study were perhaps those who felt interested and most concerned by this subject.
- Investigation bias: The questionnaire does not constitute a validated measurement tool. It was designed after carrying out a literature review. The questionnaire was carried out so that the participants give their feelings at the precise moment when they answer the survey. The online questionnaire does not allow questions to be asked of users face to face, the questions can be interpreted differently. The questionnaire explores a perception and does not assess the reality of the doctor's practice.

Conclusion

Our study shows that there are shortcomings in the knowledge of doctors and the practice of announcing a diagnosis of cancer. A considerable effort is therefore to be devoted to training which can improve doctor-patient communication skills. Even if doctors trained in the field of publicity would better practice publicity, updating their knowledge and renewing training are essential to develop their skills. Awareness of untrained doctors and their involvement in continuing medical education programs should be considered.

Likewise, learning to report bad news is essential from the first years of medical studies. This could be done through the implementation of a program aimed at developing relational skills and based on active methods (role plays) within the framework of the simulation center.

Annex 1: Questionnaire "Announcement of a cancer diagnosis: analysis of the situation in the Sfax teaching hospitals"

1/ Have you had any training:

Communication? !__ ! In "health simulation"? !__ !

To "role plays"? !__ ! In onco-psychology? !__ !

Any !__ !

2/ Do you know the different theoretical stages of the announcement of bad news?

Yes !_! No !_!

3/ Are you faced with a cancer diagnosis announcement

Not at all !_! Rarely !_! Often !_! Always !_!

4/ Do you express the need to learn about the tumor pathology (prognosis, therapeutic means) before announcing the diagnosis of cancer?

Yes !_! no !_!

5/ Do you ever want to make this announcement yourself?

Yes !_! no !_!

6/ Have you planned a consultation appointment to announce the diagnosis of cancer?

Yes !_! No !_!

7 / Is it possible for you to schedule a reasonable time for this announcement?

Yes !_! no !_!

8 / What do you think is reasonable time?

15 mins !_! 30mn !_! 45mn !_!

9/ Do you have difficulty finding a simple and accessible vocabulary for the patient?

Yes !_! no !_!

10/ What do you think about the use of terms in Arabic:

Recommended !_! To avoid !_! Possible !_!

11/ Do you have the opportunity to prepare the environment for the announcement?

Yes !_! no !_!

12/ Do you have the opportunity to prepare the environment for the announcement?

Yes !_! no !_!

13/ Do you have the option of choosing the right time for the announcement?

Yes !_! no !_!

14/ Do you ask the patient about his experience before the announcement?

Yes !_! no !_!

15/ Do you take into account what the patient wants to know?

Yes !_! no !_!

16/ Do you take into account what the patient already knows about their health?

Yes !_! no !_!

17/ Should the announcement be made to the attendant and not to the patient?

Yes !_! no !_!

18/ Do you think the presence of a companion is essential during the announcement?

Yes !__! no !__!

19/ Do you identify the patient's companion?

Yes !__! non !__!

20/ Do you think the announcement should be made:

During a consultation !__! During several consultations !__!

21/ Do you inform your patient of the prognosis of his illness in a curative situation?

Not at all !__! Rarely !__! Often !__! Always !__!

22/ Do you inform your patient of the prognosis of his illness in a palliative situation?

Not at all !__! Rarely !__! Often !__! Always !__!

23/ Do you explain the therapeutic possibilities to the patient in a curative situation?

Not at all !__! Rarely !__! Often !__! Always !__!

24/ Do you explain the therapeutic possibilities to the patient in a palliative situation?

Not at all !__! Rarely !__! Often !__! Always !__!

25/ Do you communicate survival figures to the patient in a curative situation?

Not at all !__! Rarely !__! Often !__! Always !__!

26/ Do you communicate survival figures to the palliative patient?

Not at all !__! Rarely !__! Often !__! Always !__!

27/ Do you give hope to your curative patient?

Not at all !__! Rarely !__! Often !__! Always !__!

28/ Do you give hope to your palliative patient?

Not at all !__! Rarely !__! Often !__! Always !__!

29/ Do you feel able to explore the patient's emotions during the announcement?

Yes !__! no !__!

30/ Should we check the patient's understanding after the announcement?

Yes !__! no !__!

31/ Do you think checking understanding is another trauma to avoid?

Yes !__! no !__!

32/ Do you allow time to answer the patient's questions after the announcement (during the same consultation)?

Yes !__! No !__!

33/ Are you able to give emotional support to the patient after the announcement?

Yes !__! no !__!

34/ Do you ever refer your patient to a psychiatrist after the announcement

Not at all !__! Rarely !__! Often !__! Always !__!

Bibliography

1. Buckman R. "Breaking bad news: why is it still so difficult?" *British Medical Journal* 288 (1984): 1597-1599.
2. Ptcek J and Eberhardt TL. "Breaking bad news. A Review of the Literature". *The Journal of the American Medical Association* 276 (1996): 496-502.
3. Ong LM., et al. "Patient communication: a review of the literature". *Social Science and Medicine* 40 (1995): 903-918.
4. Baile WF., et al. "SPIKES a six steps protocol for delivering bad news: Application to the patient with cancer". *The Oncologist* 5 (2000): 302-311.
5. Libert Y and Reynaert C. "L'annonce de mauvaises nouvelles en oncologie: observations et formations". *Tempo Médical* 334 (2011): 23.
6. Albrecht TL., et al. "Influence of clinical communication on patients' decision-making on participation in clinical trials". *Journal of Clinical Oncology* 26 (2008): 2666-2673.
7. Lienard A., et al. "Factors that influence cancer patients' anxiety following a medical consultation: impact of a communication skills training programme for physicians". *Annals of Oncology* 17 (2006): 1450-1458.
8. Cartier-Chatron I., et al. "Formation à l'annonce en oncologie par la simulation: implications psychologiques et place du psychologue". *Psycho-Oncology* 8 (2014): 200-204.
9. Hélène Brocq. "Éthique et annonce de diagnostic: Informer ou l'art de mettre les forms". *Le Journal Des Psychologues* 259 (2008): 65-69.
10. Leone D., et al. "Breaking bad news in assisted reproductive technology: a proposal for guidelines". *Reproductive Health* 20 (2017): 148.
11. Fallow field L and Jenkins V. "Communicating sad, bad, and difficult news in medicine". *Lancet* 363 (2004): 312-319.
12. Girgis A and Sanson-Fisher RW. "Breaking bad news: consensus guidelines for medical practitioners". *Journal of Clinical Oncology* 13 (1995): 244-256.
13. Back AL., et al. "What patients value when oncologists give news of cancer recurrence: commentary on specific moments in audio-recorded conversations". *Oncologist* 16 (2011): 342-350.
14. Clayton JM., et al. "Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their care givers". *Medical Journal of Australia* 186 (2007): S77.
15. Devallez F., et al. "L'annonce de mauvaises nouvelles en oncologie: l'expérience belge". *Revue des Maladies Respiratoires* 31 (2014): 721-728.
16. Buckman R. "Communication skills in palliative care". *Neurologic Clinics* 19 (2001): 989-1003.
17. Cooley CM. "Communication Skills in Palliative Care". *Handbook of Palliative Care, Second Edition* (2005).
18. Tan CE., et al. "Preferences of Malaysian Cancer Patients in Communication of Bad News". *Asian Pacific Journal of Cancer Prevention* 13 (2012): 2749-2752.

19. Ahmed Salem and Abdel-Fattah Salem. "Breaking Bad News: Current Prospective and Practical Guideline for Muslim Countries". *The Journal of Cancer Education* 3 (2013): 523-528.
20. Abha R., et al. "Breaking Bad News: Patient Preferences and the Role of Family Members when Delivering a Cancer Diagnosis". *Asian Pacific Journal of Cancer Prevention* 17 (2016): 1779-1784.
21. Bumb M., et al. "Breaking Bad News: An evidence-based review of communication models for oncology nurses". *Clinical Journal of Oncology Nursing* 21 (2017): 573-580.
22. Chittem M and Butow P. "Responding to family requests for non disclosure: The impact of oncologists' cultural background". *Journal of Cancer Research and Therapeutics* 11 (2015): 174-181.
23. Bettevy C Dufranc and G Hofmann. "Critères de qualité de l'annonce du diagnostic: point de vue des malades et de la ligue nationale contre le cancer". *Risques et Qualité* 3 (2006): 67-72.
24. Vannotti M. "L'empathie dans la relation médecin – patient". *Cahiers critiques de thérapie familiale et de pratiques de réseaux* 2 (2002): 213-237.
25. Holland JC., et al. "Psycho-oncology". 2nd edition. New York: Oxford University Press (2010).
26. Orjubin D and Cheneau AFIC C. "Annonce du diagnostic et accompagnement psychologique". *Bulletin Infirmier du Cancer* 7 (2007): 19-20.
27. Coutinho F., et al. "An Overview of Teaching Communication of Bad News in Medical School: Should a Lecture be Adequate to Address the Topic?" *Acta Medica Portuguesa* 29 (2016): 826-831.
28. Millette B., et al. "L'apprentissage de la communication par les médecins: aspects conceptuels et méthodologiques d'une mission académique prioritaire". *Pédagogie Médicale* 5 (2004): 110-126.
29. Fujimori M., et al. "Effect of Communication Skills Training Program for Oncologists Based on Patient Preferences for Communication When Receiving Bad News: A Randomized Controlled Trial". *Journal of Clinical Oncology* 32 (2014): 1-8.
30. Gorniewicz J., et al. "Breaking Bad News to Patients with Cancer: A Randomized Control Trial of a Brief Communication Skills Training Module Incorporating the Stories and Preferences of Actual Patients". *Patient Education and Counseling* 4 (2017): 655-666.
31. Bousquet G., et al. "Breaking Bad News in -Oncology: A Metasynthesis". *Journal of Clinical Oncology* 33 (2015): 2437-2443.
32. Moore PM., et al. "Communication skills training for healthcare professionals working with people who have cancer". *Cochrane Database of Systematic Reviews* 3 (2013): CD003751.

Volume 9 Issue 9 September 2020

©All rights reserved by Hanène Ben Salah., et al.