

Single cases from multiple perspectives: a qualitative study comparing the experiences of patients, patients' caregivers, surgeons, and nurses when bad news is delivered about cancer

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Abstract

Background: Qualitative literature on the experiences of those delivering and receiving bad news about cancer has revealed what these parties consider important during the process across many different patient cases. The current study aims to add to this understanding by employing a "linked case" study design to directly compare the perspectives of patients, their caregivers, and health care professionals (HCPs) involved in a series of single-patient cases of breaking bad news. **Method:** Semistructured interviews were conducted with 13 participants (5 patients, 4 caregivers, 2 surgeons, and 2 nurses) who formed 5 linked cases. Interviews were analyzed using interpretative phenomenological analysis and directly compared within each linked case. **Results:** Analyses identified 2 main superordinate themes. The first labeled "accurately perceiving and responding to needs," included HCPs recognizing and responding to patients' and caregivers' individual emotional and informational needs. The second labeled "carers fulfilling necessary roles," identified the various roles HCPs and patients' caregivers took to satisfactorily meet patients' needs. **Conclusions:** The findings suggest the importance of HCPs accurately perceiving and responding to patients' and caregivers' various needs and caregivers ability and willingness to fulfilling support roles in a way that aligns with their own resources and patients' needs. This highlights the value of HCPs developing and applying interpersonal skills within bad news encounters, working as a team, and exploring caregivers' resources for patient support.

Keywords: Breaking bad news, Cancer, Caregiver, Health care professional, Interpretative phenomenological analysis, Oncology, Patient, Qualitative methods

Introduction

Breaking bad news to patients is an inevitable part of working in the medical profession, and one that health care professionals (HCPs) working in cancer care may face on a regular basis. There are many moments along a patient's cancer journey that could be considered "bad news," such as receiving news of a diagnosis, test result, prognosis, relapse, or transition to palliative care.^[1] What constitutes "bad news" for someone, and the impact of the news, can vary based on an individual's expectations for their future and longevity, current life situation, past experiences,

personality, cultural and social background, beliefs, availability of support, and emotional resilience.^[2,3] Additionally, bad news can be delivered via a variety of modalities, such as in-person or over the telephone, which can affect patients differently.^[4] To capture this variation and subjectivity, a broad definition of "bad news" is needed. Ptacek and Eberhardt (1996) defined bad news as any information that "... results in a cognitive, behavioral, or emotional deficit in the person receiving the news that persists for some time after the news is received."^[5]

The process of breaking bad news can be challenging for those receiving and delivering the news. For patients, receiving bad news about cancer is typically a significant emotional event, where their futures are suddenly changed, and in some cases, shortened. This can result in a range of emotional reactions, including shock, anger, sadness, denial, relief, and acceptance.^[3,6] Literature on patients' caregivers suggests similar emotional impacts.^[2] However, caregivers can carry the additional burden of feeling they must withhold information from the patient or hide their own emotions in an effort to protect the patient from further distress.^[7,8]

For HCPs delivering the news, the complexity of communicating bad news lies in the numerous factors requiring consideration: responding to patients' and their caregivers' emotional reactions, which they can feel fearful of and inadequately trained to manage^[9]; adapting the delivery to meet individual patient's preferences and cultural needs^[10,11]; managing their emotional reactions to the bad news^[1]; and working within the time and resource demands of their workplaces.^[6] Additionally, a poor delivery has been reported to impact a patient's level of satisfaction,^[12] anxiety,^[13] and psychological adjustment to the news.^[14]

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Given the complexity of the breaking bad news encounter and the importance of this task being done effectively, numerous qualitative studies and reviews have been conducted to explore the experiences of different parties involved: patients, patients' family members or caregivers, and HCPs.^[1,7,15,16] Key considerations commonly reported in oncology include the setting (private, quiet, unrushed), tailoring delivery to a patient's preferences and cultural background, attending to the emotional reactions of those receiving bad news, and maintaining hope.

Although this existing research points to pertinent aspects of a broad range of bad news encounters, to the authors' knowledge, Furber et al's study^[16] is the only qualitative investigation to date that has used a design that enabled a direct comparison of the perspectives of patients, relatives, and HCPs involved in a single patient's case of breaking bad news about cancer. "Linking" the perspectives of these different parties within the same case highlighted whether the needs of the patient were congruent with the understanding and actions of the HCP, which has important implications for delivering satisfactory health care.^[16] Although this "multiperspectival" approach has been applied in other areas of health,^[17] this form of analysis, and the potential insights within-case comparisons can offer, are underdeveloped within breaking bad news in oncology.

The current study is exploratory and aims to further develop this within-case comparison analysis by implementing a "linked case" study design to closely examine, and directly compare, the perspectives of patients, their caregivers, surgeons, and nurses involved in the same patient's case of breaking bad news about cancer.

Methods

Interpretative phenomenological analysis (IPA) provided the theoretical framework to examine semistructured interviews exploring participants' lived experiences of the breaking bad news process, and then to directly compare patients', caregivers', and HCPs' accounts that were linked to the same patient's case. The study was phenomenological in the sense that it prioritized the way participants made sense of their personal experience of the breaking bad news encounter; and grounded in hermeneutics, whereby both the participants and the researcher engaged in a process of interpretation to arrive at the findings.^[18] In support of the current design, Larkin et al^[19] have suggested that IPA can be applied within multiperspectival study designs to capture more complex participant experiences, while upholding the epistemological foundations of IPA. This study adheres to the reporting framework for qualitative research (see SDC, Table 1, <http://links.lww.com/OR9/A15>).^[20]

Data collection

Patients and caregivers were recruited through the hospital- and community-based health care workers who cared for patients diagnosed with cancer at a hospital in the North Island of New Zealand. Patients were eligible to participate if they were 18 years and older and had been through a surgical treatment process for cancer that involved receiving bad news. The current study allowed patients to self-identify what they considered to be "bad news" in their interactions with HCPs in the surgical departments, reflecting the subjective nature of this concept as outlined in the literature.^[3] The focus on surgical departments was driven by the interests of a district cancer care group (consisting of HCPs) in getting a better understanding of the bad news

processes that are followed. Patients were to be at least 3 months post-surgery so they were more likely to be in a position to reflect on their experiences without the burden of having recently received bad news and undergone surgery. Caregivers were relatives, or nonrelatives, who were present when the patients received bad news within the hospital's surgical department and were 18 years and older.

Patients and caregivers contacted the primary author expressing their interest in participating, and an interview was arranged. Patient and caregiver interviews occurred 4 to 11 months post-surgery and were conducted in their homes, with 2 of the patient-caregiver dyads choosing to be interviewed together. Upon patients' consent to be part of a linked case, the surgeons and nurses involved in delivering bad news to the interviewed patients were directly contacted, inviting them to participate. For the HCPs who responded and agreed to participate, interviews were conducted individually within their place of work.

The current study sample was determined by the number of linked cases that were able to be formed from the data collected for a larger doctoral study exploring the perspectives of 4 different groups involved in the bad news process: patients, caregivers, surgeons, and nurses. The wider study's data collection ceased when the number of participants per group was sufficient to be analyzed as a stand-alone group. The current study's small sample size aligns with the idiographic principle of IPA as detailed analyses of individuals' lived experiences could be conducted. This is considered appropriate for an IPA enquiry as the quality and depth of the accounts are given greater priority than the quantity.^[21] The inclusion of the perspective of adult patient caregivers in the current sample attends to the under-representation of this group in the existing qualitative literature.^[7]

The interviews followed a semistructured interview schedule that was developed by the primary author and reviewed by the co-authors and an advisory group of cancer workers (established to guide the development and execution of the study; see Appendix for the interview schedule, <http://links.lww.com/OR9/A16>). Interviews went for 30 to 80 minutes, were audio-recorded, and transcribed verbatim.

Ethical approval was granted from the Health and Disability Ethics Committee (16/NTB/164) and the hospital's ethics boards.

Analysis

Interviews were analyzed following the phases of IPA outlined by Smith et al.^[18] It is recognized in IPA that findings are a result of a dual interpretation process, whereby the researcher has an active role in interpreting the participants' interpretations of their experiences, referred to as the double hermeneutic. The analysis was led by the primary author, which involved a detailed examination of 1 interview at a time, attending to IPA's idiographic commitment.^[18] The first participant's interview transcript was repeatedly read, followed by initial coding in a line-by-line fashion within the page margin to capture aspects of importance, as well as offer possible interpretations of underlying meaning. These initial codes were then integrated to develop tentative themes before the next participant's transcript became the focus. Once all interviews were individually examined, the initial codes and themes from the same linked case were compared, exploring consistencies and differences in what each participant spoke about as important when bad news was delivered. The data set was then looked at as a whole to identify superordinate and subordinate themes across the 5 linked cases.

As a means to increase the credibility of the findings, and to address the possible influence of the primary author’s previous knowledge of the topic (conducting a meta-synthesis¹⁷) and interviews that were not part of the current study) and background (Clinical Psychology trainee, living outside of the study locality) on the themes identified, the themes and supporting evidence were independently reviewed by co-authors. The co-authors had >10 years’ experience with providing psychological services to oncology patients in the study locality, as well as expertise in qualitative research methods. This process of review was to ensure that the findings were grounded in the data.

Results

Five linked cases were formed, each representing a different patient’s case of breaking bad news (see Fig. 1 for the linked case network; all names used are pseudonyms). The linked cases were made up of 13 participants, purposively sampled: 5 patients, 4 caregivers, 2 surgeons, and 2 nurses (see Table 1 for participant demographics). Two patients who consented to a linked case were not included in the study as the caregiver or HCPs involved in the patient’s case either did not respond to the invitation to participate or did not consent to participate. There were 5 surgeons identified by patients to be contacted as part of a linked case who did not respond to the invitation to participate. Three of the linked cases included the perspective of at least 1 HCP.

Two superordinate themes were identified among the 5 linked cases, labeled “accurately perceiving and responding to needs” and “carers fulfilling necessary roles,” each with 2 subordinate themes (Fig. 2). These themes are described below within the linked cases (here forth denoted by the linked case [LC] code outlined in Fig. 1) and supported by direct quotes.

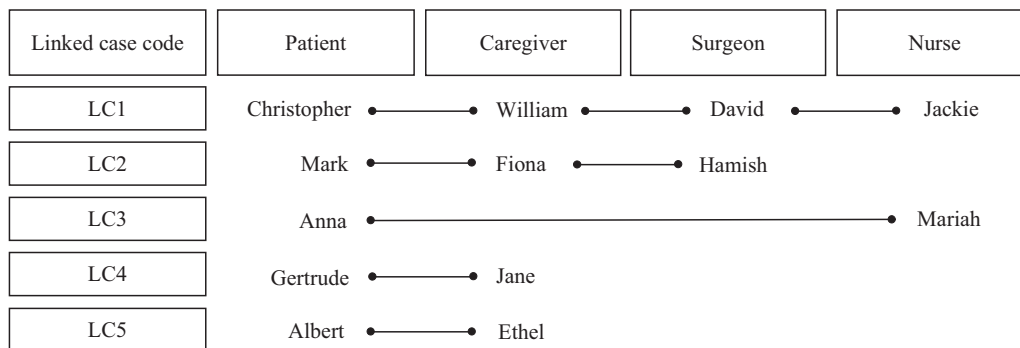
Accurately perceiving and responding to needs

During the delivery of bad news, patients and their caregivers spoke about the needs they had at the time and how these were met by those involved in their care. In linked cases that included the bad news deliverer and receiver perspective, the direct comparison highlighted the importance of HCPs recognizing and attending to patients’ and caregivers’ specific emotional needs (“noticing and meeting emotional needs”) and delivering information in the way that suited each patient (“reading different informational needs”).

| Participants | Characteristic | n |
|-------------------------|-------------------|--------------|
| Patients | Age, mean (range) | 60.2 (33–80) |
| | Sex | |
| | Male | 3 |
| | Female | 2 |
| | Ethnicity | |
| | NZ European | 4 |
| | European/Māori | 1 |
| Cancer type | Prostate | 2 |
| | Bowel | 2 |
| | Breast | 1 |
| Caregivers | Age, mean (range) | 55.3 (44–69) |
| | Sex | |
| | Male | 1 |
| | Female | 3 |
| | Ethnicity | |
| NZ European | 4 | |
| Relationship to patient | Partner/spouse | 3 |
| | Child | 1 |
| Surgeons | Sex | |
| | Male | 2 |
| Ethnicity | NZ European | 1 |
| | European | 1 |
| Nurses | Sex | |
| | Female | 2 |
| | Ethnicity | |
| NZ European | 1 | |
| European | 1 | |

Noticing and meeting emotional needs. There were several examples within the linked cases where the patient’s need for a specific form of emotional support was accurately perceived and delivered by one of the HCPs involved in their care. This was exemplified in LC3, when the nurse, Mariah, saw the importance of giving hope to the patient, Anna. Mariah explained:

They were about to start having a family- that was their focus, and then to be told, “oh wait, hang on a tick.” I know that she was very devastated at the thought that that might not be an option . . . and I just thought before we do anything, I need to give her some hope in regards to the fact that she can still have children (Nurse, LC3).



Note: All names used are pseudonyms to protect participant confidentiality.

Figure 1. Linked case network.

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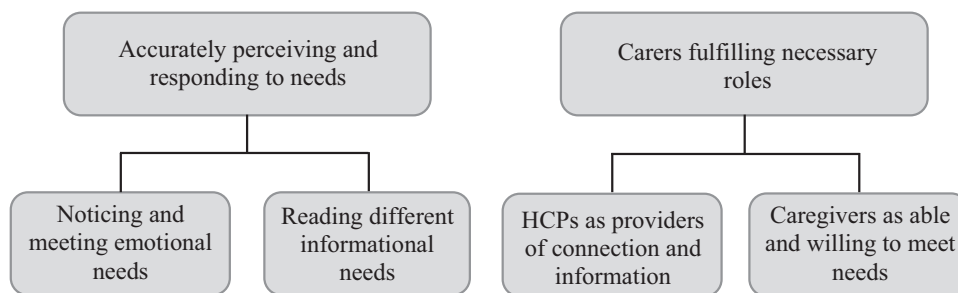


Figure 2. Illustrated coding tree of superordinate and subordinate themes.

The importance of receiving hope at that time was paralleled in the patient, Anna’s, account:

Another huge thing that has been affected by my diagnosis is my husband and I haven’t started a family yet and that’s something that we really want as soon as possible. So, when Mariah told me I would be stuck on this tablet for ten years, I immediately saw my plans for children disappear before my eyes and I was very upset. Turned out she then said there will hopefully be a way for us . . . once Mariah said there are ways, we all felt a little better (Patient, LC3).

LC2 provided an example of all those present in the bad news consultation accurately recognizing the emotional impact the news had on the patient. The patient, Mark, described how shocked he was when he received the news of his cancer diagnosis. Mark said:

Straight away, you just get angry and “why’s this happening to me?” Just lots of things raced through my mind (Patient, LC2).

Mark’s wife and surgeon demonstrated recognizing this impact in their accounts of the consultation. His wife, Fiona, and surgeon, Hamish, recalled this in the following 2 extracts:

It was sort of like, “woah” and then I could see Mark, but it was more or less like there was nothing else there and nothing else was happening. And I just was looking at his face and it just dropped and went white (Caregiver, LC2).

I do remember him being really shocked by it, his face was pretty blank (Surgeon, LC2).

It was evident that Fiona’s and Hamish’s attention was on Mark at that time, which meant the emotional impact for Mark was immediately recognized and could then be attended to.

LC1 demonstrated the importance of the bad news receiver making their emotional support needs known to HCPs in order for them to provide appropriate support. The surgeon, David, explained that his general approach to breaking bad news involved noticing when the patient’s support person(s) present needed support. David said:

So, breaking bad news is also trying to support the support person (Surgeon, LC1).

However, the patient’s partner, William, indicated that he hid his need for emotional support, despite it being present, in interactions with HCPs. William explained:

I did feel like sometimes that his doctors and that didn’t pick up when I was down, they just sort of bypassed me, but that is probably my fault because I am very self-aware and can control my feelings (Caregiver, LC1).

Thus, this case illustrates that although HCPs may be aware of the needs of caregivers, getting those needs met is a bidirectional interaction that also relies on caregivers revealing their needs to others.

Reading different informational needs. The linked cases also highlighted the impact of HCPs accurately perceiving the amount of information the patient needed at the time of breaking bad news, as this could vary from patient to patient. In LC3, the patient, Anna, stated that she needed more information than she was given by her General Practitioner who first broke the news to her of her cancer. Anna shared:

While I waited, I just thought, “I need more information. I need more. I need to know exactly what I’m dealing with here, right now” (Patient, LC3).

When Anna met nurse, Mariah, to discuss her diagnosis and treatment further, Mariah accurately perceived that Anna was the type of patient that would benefit from being well-informed, based on the number of questions she asked during the consultation. Mariah said:

So, I think there was probably a lot of information given in that initial meeting but I sense that Anna is the type of person that also needs that, you know . . . I remember her asking a lot of questions (Nurse, LC3).

Anna reflected positively on her consultation with Mariah; the congruence between her need for information and what was provided may have contributed to her satisfaction.

Although the patient, Mark, in LC2 had different information needs to Anna, his surgeon, Hamish, also accurately perceived what his needs were at the time of sharing his diagnosis. Hamish read Mark’s shocked facial expression to indicate that it would be best for him to limit the amount of information he gave Mark at that time. The surgeon, Hamish, said:

So, I do remember quite clearly Mark being pretty shocked with the news, so his wife was asking a lot of the questions initially. And I tried not to give too much specific information about the next steps . . . I was pretty confident that he wouldn’t be taking much of it in at all (Surgeon, LC2).

The accuracy of Hamish’s perception was corroborated by Mark, who recalled that his emotional reaction when being told

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of his cancer diagnosis limited the information he could absorb and he appreciated the opportunity to have subsequent consultations. The patient, Mark, explained:

And they did say like you'll probably only take in half of what you hear so they get you back again for two more consultations. And then that was really good because you only took in- I was angry, bam straight away (Patient, LC2).

These linked case comparisons of deliverer and receiver perspectives demonstrate the range of emotional and informational needs patients can have at the time of receiving bad news, and the importance of HCPs accurately recognizing and responding to these needs. In 1 linked case, it was also highlighted the importance of those in need of support communicating this and not trying to suppress their needs. It is possible that consistency between what the receiver wanted and what the deliverer provided contributed to a more satisfactory breaking bad news experience for these patients and their caregivers.

Carers fulfilling necessary roles

The linked cases revealed a variety of roles taken on by HCPs and patients' caregivers during the breaking bad news process to meet the needs of the patient. For HCPs, their roles involved covering the patient's need for information and a personal connection ("HCPs as providers of connection and information"). Within patient-caregiver dyads, successful caregiver roles arose from the resources caregivers had to offer aligning with the needs of the patient ("caregivers as able and willing to meet needs").

HCPs as providers of connection and information. It was evident that receiving information and establishing an interpersonal connection were important aspects of a patient's interaction with the HCP team at the time bad news was broken; these roles were understood to be fulfilled by the surgeon and nurse, respectively. This was illustrated in LC3, when nurse, Mariah, provided an account of her role as being focused on relationship building when she first meets the patient (Extract 1) and the surgeon's role as focusing on giving information about the next steps of treatment (Extract 2). Mariah explained:

I am hoping that's the time when I start to establish a relationship and it's really hard when you've just heard some bad news to actually link with somebody. Like they're still processing what is being said and then I'm in there saying, "ah this is who I am and this is what I do." But if anything, I hope that people can go home knowing that I will always be there for them (Extract 1; Nurse, LC3).

[The surgeon's] really good at when he explains things, but he can sometimes just shut off and say, "right, it is what it is and now we have to deal with it." Like he almost loses his- it's not that he's lost his empathy 'cos he's not like that, but he just kind of gets into this, "right, you know, this is what we are dealing with, now we've got to sort this," you know. And he gets quite um not so emotive in his responses. It's all very black and white about what we need to do, yeah (Extract 2; Nurse, LC3).

The patient in LC3, Anna, recalled her nurse and surgeon fulfilling the roles in a congruent way with how the nurse, Mariah, described them. Anna saw Mariah as being approach-

able and warm (Extract 1) and her surgeon being focused on providing a plan for treatment (Extract 2):

[Mariah] just had such a lovely, warm personality; you feel like you can just ask her anything and you never feel like any question is a stupid question" (Extract 1; Patient, LC3).

So, they pretty much said that the next step would be the mastectomy and the surgeon said, "it's usually within two weeks." But then he said, "I can actually get you in this Friday if you feel you are up to it." And I said, "yip, the quicker the better as far as I'm concerned" (Extract 2; Patient, LC3).

Anna spoke about having had a positive experience in her interactions with Mariah and her surgeon, possibly contributed to by her need for information and interpersonal connection being effectively fulfilled by someone in the HCP team.

LC1 provided another example of the deliverers and receivers of bad news having a congruent understanding of HCPs' informational and relational roles. The surgeon in LC1, David, viewed his role as providing information, indicated when he described breaking bad news as an "information process" (Surgeon, LC1). The patient's partner, William, explained that this was what he expected from the surgeon and was satisfied that he focused on delivering information:

Upfront, with all the facts, yeah . . . that was how it was done" (Caregiver, LC1).

Alternatively, William reflected on appreciating the personal relationships he formed with the nursing staff. He recalled:

Yeah, but we had different nurses in the follow-up appointments after that and they were absolutely brilliant. Couldn't, couldn't do enough . . . by the time we went in for the second or third time, it was, you know, no PC, just a hug and a hello and - real people-people (Caregiver, LC1).

The nurse in LC1, Jackie, understood her role as being focused on forming an interpersonal connection, congruent with William's understanding of a nurses' role. She said:

Yeah, and you get that rapport with them and that is probably the best part of this radical prostatectomy pathway" (Nurse, LC1).

For William, having his information and relational needs met by the surgeon and nurse (respectively) meant that, together, he received a complete package of care in the way he expected, which may have contributed to his satisfactory experience of the breaking bad news process.

Congruent with the common understanding that surgeons are the information providers, the surgeon, Hamish, in LC2 focused on how he transmitted information to the patient, Mark, when describing his role during the breaking bad news process. Hamish said:

I went through a book from a pack that we give every man diagnosed with prostate cancer about exactly what his was and what the options were" (Surgeon, LC2).

However, for the patient, Mark, he recalled the relationship he formed with his surgeon, Hamish, as the most memorable part of his interaction with him when he was told bad news. Mark said:

which could lead caregivers to not disclose when they have emotional needs that require attending to. This suggests that although HCPs have an active role in perceiving patients' verbal and nonverbal cues when assessing their needs, caregivers also have a responsibility to communicate their needs. Creating a communication context that allows caregivers to feel comfortable disclosing their needs may be a necessary pre-condition for this to occur.

The linked cases in the present study highlighted that different HCPs can work together to satisfactorily meet the information and relational needs of patients and caregivers, suggesting that the onus was not on 1 HCP to meet all of a patient's needs. Taking a team approach is supported by literature that recognizes that, although doctors are typically tasked with breaking the bad news, nurses and allied HCPs (eg, psychologists and social workers) have a crucial role in supporting patients.^[15,22,23] Nurses took an important role in providing emotional support to patients in the present study, lending further confidence in this finding in the existing literature. When HCPs who provide information also formed a personal connection with the patient, as illustrated in 1 linked case, this relationship may facilitate a smoother sharing of difficult information.

The linked cases also demonstrated that caregivers fulfill important roles such as primary caregiving and gathering information, aligning with studies that have reported family as playing a pivotal role in the process of breaking bad news.^[24] Guidelines for involving family members in difficult conversations have recently been suggested in the literature.^[25] The present findings support the explicit recognition and involvement of the caregivers in bad news discussions to support patients; however, caregivers must have the resources to offer this support and do so in a manner that meets the patient's needs. Although this was the case for the limited number of patient-caregiver dyads in the current study, this may not always be the reality.

Study limitations

The linked case study design enabled the direct comparison of the experiences of the patient, caregivers, surgeon, and nurse involved in a single patient's case of breaking bad news, exploring aspects of importance from various perspectives. This can be seen as a process of triangulation and strengthens the comprehensiveness of the findings drawn from this study.^[19,26] However, only one of the linked cases was complete (ie, patient, caregiver, surgeon, and nurse) and 2 of the linked cases did not include the perspectives of a HCP. The completeness of the linked cases was influenced by the challenges faced with the recruitment of HCPs for linked cases, which may have been driven by limitations of the recruitment strategy or competing demands of HCPs' busy workloads. Refinement of the recruitment strategy through means such as enhancing commitment in the conducting of the study from staff at all levels of the organization and greater visibility of the study within the study locality may be beneficial for future applications of the linked case design that involved HCPs. Although the small sample size was considered appropriate from a methodological standpoint,^[18] the completeness of the linked cases is an important contextualizing variable when considering the broader applicability of the findings.

The context in which the data were collected also warrants consideration. Interviews occurred 4 to 11 months after the patient's surgery, representing a delay between the delivery of bad news and when the interviews were conducted. Although patients and their caregivers appeared to be able to recall the specific

details of receiving bad news, the surgeons and nurses had some difficulty. The length of the time may have limited the depth and accuracy of the details HCPs were able to recall, given the high volume of patients they encounter. Additionally, 2 patients and their caregivers chose to be interviewed together, which may have influenced how congruent their experiences were reported to be in this study. Furthermore, there is a potential for a participation bias whereby the patients who agreed to participate may have had better rapport with HCPs and the HCPs who agreed to participate may have been more attentive to patients' needs. Although the recruitment was not limited to patients with successful surgical treatment outcomes, this was the case for all the patients in the study, and possibly influenced how each party reflected on the time when bad news was broken. Once again, these present as important contextualizing variables when considering the applicability of the findings.

The present study was limited to surgeons and nurses that deliver cancer-related bad news. The literature reports the valuable role that allied HCPs can play in the breaking bad news process, especially as patients adjust to the reality of their illness.^[22,23] As the process of breaking bad news has aspects of significance in the lead-up, actual delivery, and aftermath,^[7] future studies applying the linked case design longitudinally with interviews at multiple time points may capture the involvement of various HCPs as the patient makes sense of their bad news and the implications.

Clinical implications

The emphasis on interpersonal skills in the current findings suggests this as a key aspect when training HCPs to effectively deliver bad news. The variation in the needs of individual patients across the linked cases points to supporting HCPs to develop skills in assessing the needs of each patient and adjusting their delivery and response accordingly, which the HCPs in our small sample appeared to do accurately. HCPs are encouraged to access training programmes that include interpersonal skills in eliciting, attending to, and responding to patients' individual needs in the context of bad news disclosure. To support HCPs in accurately identifying the needs of those they are breaking bad news to, HCPs should encourage caregivers to make their needs known.

Once the patient's needs are accurately identified, the current findings suggest that HCPs do not have to fulfill the patient's informational and relational needs on their own, unless they have the capacity to do so. If, for example, a surgeon is aware that their skill set lies in transmitting clinical information and their time is limited, 2 linked cases indicated that the receivers of bad news can find it acceptable for a nurse to be the one they form a personal relationship with, and indeed, this may be the roles they expect each to fulfil. What appeared important in the present study was that the patient's need for both information and personal connection were attended to by someone within the HCP team. It is recommended that HCPs reflect on their strengths and available resources (eg, time) and recruit other members of the team to support them to provide a complete package of care for patients and their caregivers.

The current findings also suggest that caregivers can successfully fulfil important support roles for patients when there is congruence between the patient's needs and the resources the caregiver can offer. In practice, it is recommended that HCPs assess the capabilities and resources of caregivers to provide support while upholding the patient's autonomy to decide how their caregivers are involved.

Conclusions

Patients and caregivers have a range of emotional and informational needs when bad news is delivered about cancer. They can benefit from HCPs accurately perceiving and responding to these needs and fulfilling the roles of the information provider and relationship developer within the HCP team. Caregivers can also meet the patient's needs during the bad news process by utilizing their resources and capabilities. These findings recommend that HCPs develop and utilize interpersonal skills, work as a team, and draw on patients' caregivers to support patients when breaking bad news.

Conflicts of interest statement

The authors declare no conflicts of interest.

References

- [1] Bousquet G, Orri M, Winterman S, Brugiere C, Verneuil L, Revah-Levy A. Breaking bad news in oncology: a metasynthesis. *J Clin Oncol* 2015;33:2437–2443.
- [2] Buckman R. How to Break Bad News: A Guide for Health Care Professionals. Toronto, Canada: University of Toronto Press; 1992.
- [3] Fallowfield L, Jenkins V. Communicating sad, bad, and difficult news in medicine. *Lancet* 2004;363:312–319.
- [4] Salander P. Bad news from the patient's perspective: an analysis of the written narratives of newly diagnosed cancer patients. *Soc Sci Med* 2002;55:721–732.
- [5] Pracek JT, Eberhardt TL. Breaking bad news: a review of the literature. *JAMA* 1996;276:496–502.
- [6] Warnock C, Buchanan J, Tod AM. The difficulties experienced by nurses and healthcare staff involved in the process of breaking bad news. *J Adv Nurs* 2017;73:1632–1645.
- [7] Matthews T, Baken D, Ross K, Ogilvie E, Kent L. The experience of patients and their family members when receiving bad news about cancer: a qualitative meta-synthesis. *Psychooncology* 2019;28:2286–2294.
- [8] Friedrichsen MJ, Strang PM, Carlsson ME. Receiving bad news: experiences of family members. *J Palliat Care* 2001;17:241–247.
- [9] Alexander DA, Klein S. Bad news is bad news: let's not make it worse. *Trauma* 2000;2:11–18.
- [10] Windsor JA, Rossak JI, Chaung D, Ng A, Bisset IP, Johnson MH. Telling the truth to Asian patients in the hospital setting. *NZ Med J* 2008;121:92–99.
- [11] Naseem S. "Breaking breast cancer news" with ethnic minority: a UK experience. *J Multidiscip Healthc* 2018;11:317–322.
- [12] Brown VA, Parker PA, Furber L, Thomas AL. Patient preferences for the delivery of bad news: the experience of a UK cancer centre. *Eur J Cancer Care* 2011;20:56–61.
- [13] Goa Z. Delivering bad news to patients: the necessary evil. *Journal of Medical Colleges of PLA* 2011;26:103–108.
- [14] Roberts CS, Cox CE, Reintgen DS, Baile WF, Gibertini M. Influence of physician communication on newly diagnosed breast cancer patients' psychological adjustment and decision-making. *Cancer* 1994;74:336–341.
- [15] Abazari P, Taleghani F, Hematti S, Ehsani M. Exploring perceptions and preferences of patients, families, physicians, and nurses regarding cancer disclosure: a descriptive qualitative study. *Support Care Cancer* 2016;24:4651–4656.
- [16] Furber L, Cox K, Murphy R, Steward W. Investigating communication in cancer consultation: what can be learnt from doctor and patient accounts of their experience? *Eur J Cancer Care* 2013;22:653–662.
- [17] Smith LJ, Shaw RL. Learning to live with Parkinson's disease in the family unit: an interpretative phenomenological analysis of well-being. *Med. Health Care Philos* 2017;20:13–21.
- [18] Smith JA, Flowers P, Larkin M. Interpretative Phenomenological Analysis: Theory, Methods And Research. Los Angeles: Sage Publications Inc; 2009.
- [19] Larkin M, Shaw R, Flowers P. Multiperspectival designs and processes in interpretative phenomenological analysis research. *Qual Res Psychol* 2019;16:182–198.
- [20] Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *IJQHC* 2007;19:349–357.
- [21] Eatough V, Smith JA, Willig C, Stain-Rogers W. Interpretative phenomenological analysis. *The SAGE Handbook of Qualitative Research in Psychology*. London: Sage Publications Ltd; 2017;193–211.
- [22] Butow PN, Dowsett S, Hagerty R, Tattersall MHN. Communicating prognosis to patients with metastatic disease: what do they really want to know? *Support Care Cancer* 2002;10:161–168.
- [23] Oikonomidou D, Anagnostopoulos F, Dimitrakaki C, Ploumpidis D, Stylianidis S, Tountas Y. Doctors' perceptions and practices of breaking bad news: a qualitative study from Greece. *Health Commun* 2017;32(6):657–666.
- [24] Datta SS, Tripathi L, Varghese R, et al. Pivotal role of families in doctor-patient communication in oncology: a qualitative study of patients, their relatives and cancer clinicians. *Eur J Cancer Care* 2017;26(5):1–8.
- [25] Laidsaar-Powell R, Butow P, Boyle R, Juraskova I. Facilitating collaborative and effective family involvement in the cancer setting: guidelines for clinicians (TRIO Guidelines-1). *Patient Educ Couns* 2018;101(6):970–982.
- [26] Mays N, Pope C. Assessing quality in qualitative research. *BMJ* 2000;320(7226):50–52.