ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

SCHOOL OF PUBLIC HEALTH

Breaking bad news: Experience of health professionals and patients regarding chronic illnesses in Black Lion Specialized Hospital Addis Ababa

BY

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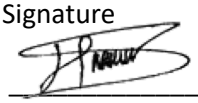
Simegnew Handebo		July 31, 2024
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Acronyms

AAU – Addis Ababa University

ABCDEs – A protocol in breaking bad news

BBN – Breaking bad news

CA – Cancer

HCP – Health care professionals

MOH – Ministry of health

NCD – Non communicable diseases

OPD – Out patient department

SPIKES – A protocol in breaking bad news

TASH – Tikur Anbassa Specialized Hospital

WHO – World health organization

Abstract

Introduction: Breaking bad news is a critical aspect of healthcare that significantly impacts patients, especially those with chronic diseases like diabetes, heart disease, and cancer. Existing research mainly examines the actions of healthcare providers, neglecting the experiences and needs of patients. This study aims to bridge that gap by exploring both healthcare providers' and patients' perspectives. By doing so, it seeks to improve the quality of doctor-patient communication and help healthcare professionals understand the emotional, social, and physical aspects of breaking bad news.

Objective: To explore the experiences first-time diagnosis of patients' with chronic illness and health care providers' on breaking bad news.

Method: This qualitative study adopted descriptive qualitative study design. We employed purposive criterion qualitative sampling method. A total of 28 participants were included: 15 health care providers and 13 patients. Data was collected in an in-depth interview in Tikur Anbassa Specialized Hospital, Addis Ababa. Data was transcribed in Amharic and then translated into English. Thematic analysis of the translated data was done using the Atals.ti software version 20.4.

Results: From a total of 43 patients and health care providers approached 13 patients and 15 health care providers participated. Based on the experiences of the participants using the quotes that best addresses the objectives of the study a total of 9 categories emerged: 1. Under recognized action in routine healthcare practices 2. Independent skill development due to training gap 3. Importance of empathetic communication in delivering bad news 4. Complex impact of family presence on patient communication 5. Need for culturally sensitive communication 6. Emotional complexity in delivering and receiving bad news 7. Critical role of coping mechanism for providers and patients 8. Communication gaps in patient understanding of diagnosis and 9. Discrepancy between patient information needs and provider perception

Conclusions: The study reveals that breaking bad news is a routine but often overlooked task in healthcare, lacking formal training and requiring emotional resilience. Effective communication, both empathetic and culturally sensitive, is crucial yet often inadequate. Family presence can help or hinder the process. Delivering bad news impacts both providers and patients emotionally, highlighting the need for strong coping mechanisms. Significant gaps in patient understanding and patient needs and provider perceptions call for improved communication strategies.

Keywords: Breaking bad news, chronic illnesses, health care professionals, patients

1. Introduction

1.1. Background

Bad news is any information that is likely to change a patient's view of his or her future in a big way, whether it's a diagnosis or the failure of a cure (1). Breaking bad news is the act of telling the patient this bad news (2). There are several ways to tell a patient bad news using patient-centered communication techniques and methods (3).

Chronic diseases, also called non-communicable diseases (NCDs), are long-lasting conditions or illnesses that are usually caused by a number of different risk factors (genetic, physiological, behavioral, etc.). (4). Chronic diseases are also conditions that need ongoing medical care or make it hard to do things you normally do (5). When it comes to people with long-term illnesses, bad news plays a big role (6).

Diabetes, heart disease, and cancer are some of the chronic diseases that are causing the number of deaths to rise (7). The 2019 World Health Organization report on World Health Statistics says that NCDs have a big effect on countries with low and middle incomes like Ethiopia. In these countries, it is the cause of 78% of all deaths, 85% of early deaths, and 50% of disabilities (8).

Primary care consultation where the doctor and patient agree is one of the most important things that lead to better medication adherence (6). Regarding the mechanisms on how to tell bad news there are only few protocols even in well developed countries like the United States, Germany, and the United Kingdom that have been around for a long time. These protocols are mostly based on the opinions of experts and less on real-world evidence (2).

The SPIKES protocol, which was written by Walter F. Baile and published in 2000, is one of the best and most widely used ways to spread bad news around the world. It has become very well-known and is used in all kinds of communication. Rabow and McPhee also came up with a plan called ABCDE for giving bad news. And so far, Ethiopia doesn't have a clear plan for how to share bad news (9).

The name SPIKES refers to the sequence of actions required for effective communication. The process of preparing for a talk begins with S (Setting up), followed by P (Perception) and I (Invitation), where the physician assesses the patient's perception of the situation and their readiness to receive news. This is followed by K (Knowledge). The next step is to respond appropriately to the patient's emotions (E). The S (Strategy & Summary) endpoint assesses the patient's understanding of the issue and treatment options. Otherwise, the communication falls short of its intended purpose (10).

The acronym ABCDE refers to the sequence of acts necessary for successful communication of bad news. The process of preparing for the talk begins with A (Advance Preparation), in which the practitioner collects all essential medical information and creates a supportive environment. This is followed by B (Create a Therapeutic Environment/Relationship), which focuses on creating a private, distraction-free environment to foster trust and reassurance. The following phase is C (Communicate Well), which entails delivering the news in a plain manner, avoiding jargon, and giving time for patient inquiries and processing. D (Dealing with Patient and Family Reactions) necessitates active listening and sympathetic interaction to resolve emotional reactions. The last phase, E (Encourage and Validate Emotions), evaluates the patient's comprehension of the problem and makes sure they feel supported (11).

1.2. Statement of the problem

Even though the doctor-patient communication is important, there aren't many formal training courses for practitioners, and there aren't any programs that teach residents and fellows how to communicate this information well (12). Some books have about bad news from the point of view of doctors. Some studies that emphasize on the need to understand the patient's point of view (13).

There is a big problem with doctors and students not knowing how to tell bad news in a standard way. Improvements are needed in knowledge, attitude, skills, and practice of using the protocols. There is a lack of research in Ethiopia and among developing nations in general on the knowledge and application of such protocols, patient preferences for its elements, and patient satisfaction (9). There isn't much research on how people with chronic illnesses and their families want to hear bad news in Ethiopia (14).

Most of the studies we identified regarding breaking bad news are quantitative. Most measure the steps taken by doctors and the durations of the encounters. These researches also investigate the actions of the health professionals from the patient's perspective. This is in addition to the small amount of researches that have been done in Ethiopia (9).

1.3. Significance of the study

Any effort to improve physician-patient communication is viewed as essential to the task of caring for the sick. This includes breaking unpleasant news as part of such communication (1). Any effort to comprehend and encourage agreement between a doctor and a patient may improve primary care outcomes (6).

There aren't many new papers on this topic that we came across, and the majority of studies done on it date back more than 15 years. Therefore, completing this study will help the viewers to acquire the most recent information on the subject. This is specifically true in the context of Ethiopia.

By carrying out this study, we can better understand the many strategies used by healthcare professionals to deliver bad news and the various aspects (emotional, social, or physical) that may influence the process.

Understanding the patients' process for receiving bad news and the variables at play is also significantly impactful. Its concurrent nature, which involves both doctors and patients, will provide a clearer image of the area and the need for additional research.

Without this study, we may be unable to understand the reasoning behind doctors' practices for delivering bad news and may overlook critical patient perspectives that could have made future processes for communicating bad news go more easily.

2. Literature review

2.1. Breaking bad news

Breaking bad news to patients is one of a practicing clinician's most practiced and important tasks. In hospitals, it's common procedure to deliver bad news, especially to patients with chronic, life-limiting conditions (2). Training was found to be a key component of competency in following SPIKES protocol and successfully delivering bad news (2, 15). It is recognized that very few healthcare professionals receive adequate training in "breaking bad news" techniques (16). In a research conducted in Sudan to examine doctors' understanding of and opinions on the practice of telling patients and loved ones terrible news, only 56.3% of the participating doctors had formal education and training (2). And in some other institutes assessed for training module preparation, there was absolutely no formal training (12).

According to a comparable study conducted in a hospital in Ethiopia, 83.8% of participants lacked training and 82% were unaware of the process. A little more than half of the doctors claimed to have experienced depression following disclosure (9).

The clinician, patients, and relatives are all affected when bad news is delivered (2). Communication abilities are crucial in this regard because the way the messenger presents the news may have a significant impact on how that news is received (15).

Unmet communication demands of patients are linked to unfavorable emotional reactions and have an impact on the decision to continue medical treatment (13, 17). One study found an important association between doctor-patient concordance and medication adherence. It specifically addresses how primary care visits in which patients experienced more concordance with their clinicians were related with a 33% improvement in drug compliance (15).

2.2. Physician’s perspective

Delivery bad news can be difficult, both for the recipient and for the one doing the delivering. According to one study, there are a variety of factors, such as the patient's needs and working circumstances, that might affect how difficult it is to break bad news to HCPs (18). According to another essay, the act of "Breaking terrible news" is undervalued. It should be acknowledged as a

challenging, unavoidable, and frequent task in clinical treatment that causes stress and anxiety for many doctors. This article asserts that the process entails much more than merely information dissemination, and it goes on to suggest a total redesign of communication tactics, including the removal of the obligation for health practitioners to give unfavorable news (19).

Various studies have documented the emotional reactions that doctors have while delivering terrible news. According to a study conducted to discover how healthcare professionals view end-of-life communication, everyone is psychologically and generally impacted by the procedure. One expert quoted in the article explains how unexpected deaths, in particular, shock people and cause them to have sleep deprivation as a result (20). Another study found that using experimental approaches to announce death causes great stress for medical personnel (13).

The bad feelings connected to the practice are categorized by a meta-analysis done to assess healthcare professionals' experiences of breaking bad news. It states that medical staff members feel stressed before, during, or after the procedure, become emotionally attached to patients after disclosing the bad news or become equally affected by it, feel unqualified to carry out the procedure, and feel as though they aren't given enough time to process as people (21).

A quantitative study done in the united states to investigate the attitudes of hemato-oncology fellows directors' towards current curriculum used to train fellows in breaking bad news found that 24% found it inadequate and the majority of them mentioned that they would like to see improvement on how their fellows are trained (22).

2.3. Patient's perspective

Effective patient-physician communication has meeting patients' needs at its core. Meeting patient's needs is not only the skills regarding the communication of bad news but also addressing the specific needs of their condition (17).

One study, on understanding perspectives of BBN in intracranial tumor patients, states at least 55% of the patient's preferred face-to-face communication, having their doctor pay close attention to them, and maintaining eye contact. Direct physical contact (15%), another healthcare professional being present while getting the news (54%), and the doctor's assistance in alerting family members (54%) were the three preferences that patients identified as least favoring (17).

Tang and Lee conducted a mixed-method study in Taiwan and found that patients preferred their doctors to inform them more than their family members. These results supported the concept that most patients preferred disclosure in the absence of a caregiver. (23, 24)

Most patients felt that the resident doctors' explanations of the situation and prognosis were brief, incomplete, and straightforward. Even some of the parents claimed that challenges with medical terminology, linguistic differences, and conflicting perspectives are to blame for the failure to communicate (20).

In northern Florida, a study investigating coping mechanisms among patients with chronic illnesses mentions the critical role of effective coping strategies in managing the stress associated with these conditions. The study highlighted that coping strategies could be categorized into problem-focused approaches, which aim to solve or alter the source of stress, and emotion-focused approaches, which seek to manage the emotional response to stress, particularly when the illness's course and outcomes remain uncertain (25).

Research conducted in China revealed that a longer duration with a chronic illness correlates with a better understanding of the condition. This finding emphasizes the importance of time in developing comprehensive disease knowledge. Furthermore, another study in China indicated a pressing need for health information immediately following a diagnosis, suggesting that timely education is crucial for newly diagnosed patients to manage their conditions effectively (26).

A Canadian study exploring the information needs and comprehension of health information among culturally and linguistically diverse populations identified significant challenges these groups face. The study found that language and cultural barriers impede the understanding and management of chronic illnesses. It emphasized that effective strategies must extend beyond mere translation to include culturally sensitive approaches that address these unique barriers comprehensively (27).

In Ethiopia and other developing countries, there is a dearth of information on patient preferences, patient satisfaction, and patient knowledge of and adherence to standards for delivering bad news (9). There are few studies available on communication in healthcare, and chronic illnesses are poorly understood (21, 24).

Additionally, there is a scarcity of research specifically addressing patient preferences, satisfaction, and adherence to standards for delivering bad news in Ethiopia and similar contexts, highlighting a critical gap that needs to be addressed. Therefore, conducting a study in Ethiopia on breaking bad news is essential to bridge these gaps, improve patient-physician communication, and enhance the overall quality of care for patients facing life-limiting conditions.

3. Objective

3.1. General objective

The objective of this study was to look at the experiences of health care providers and patients with chronic illnesses during the health communication part of the diagnosis process.

3.2. Specific objective

To explore patients' experiences when they are first diagnosed with a chronic illness

To investigate practitioners' practices and the factors that influence patient – clinician communication

To explore the impacts of breaking bad news on both health care professionals and patients

4. Methods

4.1. Study setting

The study was conducted in Black lion teaching hospital, Addis Ababa. The Black Lion Hospital is Ethiopia's largest specialized and referral public hospital. It also serves as a teaching center for health professionals, such as undergraduate and postgraduate medical students. It provides comprehensive services to NCDs for diverse populations that come from all over the nation. The study was conducted from April 2023 to June 2023.

4.2. Study approach

The study employed a descriptive qualitative study design to describe current practices and experiences among health professionals who treat patients with chronic illnesses and patients who have follow up for chronic illnesses.

4.3. Study participants

The study included two sets of study groups. The first set of our samples consisted of health professionals in Tikur Anbassa Teaching Hospital. The participants in this set were chosen based on having the responsibility of informing patients on their health status. The second set of out samples comprised of chronic illness patients who had follow up in TASH. The patients were chronic illness patients particularly those who were diagnosed with DM, cardiac illness, or cancer and who have been having follow up in the hospital. Patient participants were identified in the OPDs of the hospital and health care professionals from the wards and OPDs.

4.4. Sample size determination

Sampling was determined by purposive criterion sampling method until no further information could be acquired. The criterion for patients was age more than 18 years old, medically stable, Amharic speaker, and those who are already diagnosed with diabetes, cardiac conditions, and cancer and are on follow up. The criteria for sample selection were strategically defined to align with the available financial resources, time allocations, and accessible resources, optimizing the

study's execution within the existing opportunities. The criterion for HCPs was medical doctors who directly work with patients with chronic illnesses at the time of the study period.

4.5. Data collection Method

The interview took place with participants that were willing to participate. Data was collected using semi structured guiding questions prepared for in depth interviews. Two sets of interview questions were developed specific to the study objectives through review of various literatures. The sets were different in which it was developed for patients and health care professionals independently. The questions were first developed in English and translated into Amharic. Data was collected by the principal investigator using the interview guide. The interviews took place in empty nursing stations, doctors' offices, and OPDs. The interviews took up to 38 minutes. The interviews were applied for both the health professionals and patients with the respective questions. Data was collected until no further new information was obtained.

4.6. Trustworthiness

Trustworthiness will be assured in all the steps and processes involved in the data collection process. The investigator participated in all the processes of guide development, data collection, transcription, translation, and analysis.

Credibility

To insure credibility prolonged engagement and peer debriefing was done. The data collector and investigators familiarized oneself with the setup by and the process by observing and understanding the procedures of the hospital. These procedures were mainly regarding the responsibilities of health care professionals, steps taken at the time of diagnosis, and understanding the timing for follow ups of patients with the diagnosis of interest. Peer debriefing was used throughout the process by the research advisors; question development to make it easier to understand by the participant, development of codebook and once analysis was completed.

Transferability

The study contains full description of the patients and their illnesses, healthcare providers, places, and study environment, recordings were taken and the recordings were transcribed verbatim. The study included the top three most common cases from the growing chronic illnesses, and different professional in a way it allows the reader to familiarize oneself. Transcription was done by an independent agent and reviewed by the principal investigator.

Dependability

To insure dependability the study enabled all partaking individuals to be familiar with the concept of the subject matter (breaking bad news and chronic illnesses), and to go over the steps to collect quality data and make a reliable analysis. The researcher reviewed and refined all transcripts by assigning codes to the participants and repeatedly examining the transcripts to identify and understand any inconsistent data. The assigned codes were repeatedly verified by qualitative experts (advisors) until an agreement was reached on the codebook.

Conformability

It was assured by the audit trial that includes all the steps done, the processed passed, materials used and notes taken. This was used to check intentional or unintentional bias.

4.7.Data analysis procedure

Recorded interviews were transcribed verbatim to Amharic with respective notes. The transcribed interviews were translated to English. Taking 5 translated interviews from each of the participant groups a codebook was developed. Using the codebook and Atlas.ti version 24 all the translated interviews were coded. The data analyzer familiarized oneself by repetitive reading before the start of analysis and categories were identified from the codes using thematic analysis. Quotes that addressed the objective of the study were identified.

4.8.Ethical consideration

Ethical clearance and approval was obtained from Institutional Review Board (IRB) of Addis Ababa University (AAU), college of health sciences and school of public health. There was an official letter correspondence. Informed consent was taken from the participants. Respondents' information is kept private and confidential. The data collector communicated with the participants in a friendly, sympathetic, and nonjudgmental manner. Participants were informed that they could decline or abandon the study at any time; they were not forced to do so.

5. Result

5.1. Sample characteristics

Out of the 43 participants approached 28 of them did partake in the study. Out of these participants 15 were health care providers and 13 were patients. There were a total of 10 female participants; 7 were patients and 3 of them were health care providers. The overall participants' age ranges from 21 – 80. Health care providers included are interns, resident physicians, specialty physician, fellow subspecialty student, and subspecialty consultants. Patients included are diabetic patients, cardiac patients, and cancer patients.

Table 6.1.1. Health care providers' characteristics

Characteristics		Frequency
Sex	M	12
	F	3
Profession	Intern	3
	Resident physician	5
	Specialty doctor	1
	Fellow subspecialty student	3
	Subspecialty consultant	3
Age	25 - 30	6
	31 - 34	3
	35 – 40	4
	41 - 44	2

Table 6.1.2. Patient's characteristics

Characteristics		Frequency
Sex	M	8
	F	5
Condition	Cancer	5
	Cardiac illness	3
	Diabetes	5
Age	21 – 35	4
	36 – 50	5
	51 – 65	3
	66 – 80	1

5.2. Identified categories

From the study, we generated 9 categories: 1. Under recognized action in routine healthcare practices 2. Independent skill development due to training gap 3. Importance of empathetic communication in delivering bad news 4. Complex impact of family presence on patient communication 5. Need for culturally sensitive communication 6. Emotional complexity in delivering and receiving bad news 7. Critical role of coping mechanism for providers and patients 8. Communication gaps in patient understanding of diagnosis and 9. Discrepancy between patient information needs and provider perception

1. Under recognized action in routine healthcare practices

Most of the participant professionals in the study explained breaking bad news as a practice that is integrated in the clinical practice that is encountered frequently. One expert noted the experience of not just first-time diagnosis as part of breaking bad news, but also its integration into medical practice as follows:

""I actually think it is part of our carrier …. If it is a first encounter, we encounter it almost daily. .. It has been part of our carrier. That is how I see it." BLR3

This emphasized the nature of the task as a routine procedure that requires emotional resilience of the health care providers. The study also identified most of the professionals that see the process as an overlooked yet very critical and important part of the health care system acknowledging the gap in medical training and practice.

"So it is very important but I also feel that it is very unaddressed….So I think it is somehow overlooked but it is very important integral part." BLS

There were also healthcare providers who identified the process as infrequent. This highlights that some practitioners may only encounter these situations rarely, potentially impacting their familiarity. As one health care provider shared:

"Personally I have experienced it once when I was in St. Peter's, one in internship" BLR4

2. Independent skill development due to training gap

Most of the participant professionals explained the absence of training in the subject matter. They explain having no type of training included in the curriculum as a student or as a supportive training after starting professional carrier. This explains how the importance of training has been overlooked or neglected. One participant specifically stated the absence of training as follows.

".No. I have never seen on anything. Based on my medical school, one year GP, and now residency three years, not even one time." BLR1

Some explained they developed the skill to break bad news after encountering it in the clinical practice or when they faced difficulty practicing it. This still explains the absence of training and rather the efforts made by the participants to equip themselves with the appropriate skills independently.

"So, you don't actually like until you see the patients. I got like, for me, I got, I made most of my strides in this facet as a GP. So I saw other GPS how they were doing it and how my senior physicians dealt with it, you know." BLR2

It was also found in the study that even though they took the training as a student they found it hard to bring it to reality when they practice. Some physicians explain that the conditions they

practice and the inadequacy of the trainings that prevent them to fully practice the process in an appropriate and efficient manner. They supported this by explaining that it takes more than a few days of training to master the skill and excel at breaking bad news. As one professional noted:

"I don't believe the training you take for 10 days when you start internship or residency can fix it. ...I don't think this is something you learn like a medical practice."BLR3

3. Importance of empathetic communication in delivering bad news

Most of the health care professionals explained that their go to approach in breaking bad news is to stick to the fact and to make the patient understand the clinical condition that they have. This straightforward approach, while clear, may lack the necessary empathy and support that patients need during difficult times. As one professional stated:

"Most of the time, I try to tell them the existing thing. I don't sugar coat it. I try to tell as is. But I somewhat try to make them see it in a positive way, meaning for them to accept it." BLR5

This is also explained by the patients side as most of the participant patients recall the experience they had when they were told about the illness for the first time as direct. One of these patients was a diabetic patient who came to the hospital for an illness that needed a surgical intervention. She explains that she was only told the diagnosis and where to go other than any explanation or related support from the physician.

"Yes this is what he said. He didn't say anything else. Nothing more. … 'it shows you have diabetes, it has to be cured for you to have the operation'" BLD1

Most professionals acknowledge the part where a professional should approach breaking bad news to patients with possible chronic illnesses with compassion and should take time to explain it. One resident physician explained how a professional's approach to take time explaining a chronic illness affects how the patient understands their illness as the following.

" You need to bring the craft. Humanity should be established. We need to understand the thing that physicians are compassionate…I feel like we have to take at least, like the least we can do is take the time to explain things to patients." BLR2

Some patients explain how important it is for the physician to tell you in a compassionate matter and not just insensitively dumping the information. One cardiac patient in particular explains how important it is for the professionals to consider the condition of the patient in which a sudden bad news can result in dire medical complications. She explains how a physician who told her that her mild heart condition has progressed got her sick.

"That's because everything should be told smoothly. Shock is bad for heart. Heart and shock … He could have talked calmly at that time. Imagine when you were being told that you could get cured and suddenly some doctor comes and dumps it on you … After that I just got sicker, the prolapse, started to get sicker." BLC1

4. Complex impact of family presence on patient communication

Most physicians explained in the study how it is common to have attendants/carers present with the patients. They explained that their presence can interfere with breaking bad news practice because they demand critical health information to be held from the patients. This oversight how dynamic between patients and family can hinder transparent communication between healthcare providers and patients. One physician noted:

"In our country the attendants wouldn't be comfortable with talking with the patients. They wouldn't want to tell them." BLR2

Some patients explained that information related to their condition is often withheld from them, usually due to interference from their family/carers. These interferences can impact patients' ability to make informed decision. A patient with blood cancer who was receiving follow-up described how his brother interfered in the procedure in an attempt to keep him from learning the diagnosis as the following:

"A But after I came here, when they come to me, my brother told the doctor not to tell me and that he would tell me himself slowly." BLCC1

On the contrary it was found in the study that family support during diagnosis provided emotional stability and aid in comprehending and coping with the diagnosis. Some patients explained how the presence of a family member at the time of diagnosis helped them make a better decision and made the process better.

"if I didn't have my mother by my side then. I would have just gotten up and left just as I decided. I wouldn't have heard the doctor" BLCC3

5. Need for culturally sensitive communication

Most professionals explained how important it is to understand the patient's background information in breaking bad news. They explained how the approach should be individualized according to the patient's educational level, cultural background, education level, or other factors that can play a factor in patient's understanding of the condition. This approach can ensure effective communication that is respectful of patient's unique context

"The correct wording should be said in local language as the patient may not understand English. …. For example, when I disclose information for patients, I use translator for languages I couldn't speak. Mixing English while disclosing or counseling is not right way. People may not understand it …. Some says 'regularly' in the middle of local language. Sometimes I get angry at nurses and residents who mix English?" BLSS1

The study found supporting reports from the patients regarding how clear communication that is culturally appropriate is crucial for effective patient care. Some patients explained how a patients' background like education level or language can impact understanding one's illness. One patient noted:

"On speech. Not all can speak the same language now … They don't know the language. But it was supposed to … Translated to every language. The concept is different in one's language. If it can be told translated." BLCC4

6. Emotional complexity in delivering and receiving bad news

Most professionals in the study explained that breaking a bad news has a significant emotional toll on them. The responses include feeling sad, crying, felling disturbed, or the feeling of a dim future. One of the health care providers explained that there is a repetitive and cumulative negative emotional impact on him as follows:

"emmmm truly speaking sometimes it is kind of depressing. It is just like this. Comes recurrently; bad news, telling bad news, seeing people having something bad. Like it is not actually

something you just tell and go away. Somehow there is some residual thing that is left with you.." BLR3

The study found somewhat similar response from patients as most patient participants in the study explained that the impact on their emotional health is significant. One participant highlighted the profound and multifaceted impact of their diagnosis, describing a deep sense of shock, hopelessness, and loss of hope. This emotional impact can have effect on patient's mental and physical health. One patient specifically explain the emotional impact the news had on her at the time of diagnosis as follows:

"I was actually shocked at that time, I even lost hope. Just like I told you my father died because of this. It's really difficult to explain what I felt then." BLD2

Some physicians explained that it has no impact on them and move on with their day as this is just part of their carrier. One physician explained how he takes it as part of his carrier and moves on with his day raising concern on his emotional well-being and his ability to empathize with patients.

"So what I usually do is take it as just another day. Right. So there are new patients if I can make a difference in someone's life. It's very little." BLR2

Some of the patients expressed how they didn't feel any negative emotion. They explained that their diagnosis gave them relief compared to their health condition prior to that. An older male cancer patient specifically explained how the diagnosis was a light to a better life compared to the condition he was in prior to diagnosis.

" Yes I was not shocked. I didn't get into shock … I didn't feel anything. First I was just weak and I used to say that I wouldn't regret dying if my disease was identified. In the end my disease was diagnosed and I was told clearly." BLCC4

7. Critical role of coping mechanisms for providers and patients

In the study, almost all professionals mentioned that they need some form of coping mechanism to deal with the aftermath of breaking bad news. They emphasized the emotional burden of delivering such news and the necessity of having a support system to manage this stress. One

professional highlighted this by sharing her personal experience by explaining the importance of effective coping mechanisms that are necessary to maintain resilience as a health care provider.

"Saying that your kid died, it has a toll on you … But it is important you have a support system, mine was at home support system. I have it. So I had a chance you know to address that mental …. I'll talk about it address it and then come here and then have the courage to deal with it" BLS1

From our findings, most patients strive to understand their illness and cooperate based on both the information provided by healthcare professionals and their own research. This approach forms the basis of their coping strategy. This proactive approach to coping highlights the importance of accessible information and patient education. One patient described their method in detail:

" That I was going to take four rounds of maintainance and I would take it for two years. That I would stop followup after that. I read everything. … I ask a lot of questions when the seniors come " BLCC3

The study found some patients denying the existence of the condition or the diagnosis. These patients mentioned that they didn't take the appropriate measures because they couldn't accept the diagnosis. They mentioned they denied the existence of their illness and living like normal.

"I was not controlling if, atleast for 20 years, I didn't care I used to take sugar, sweets. …. My nature is that I don't like telling that I have diabetes, still." BLD4

8. Communication gaps in patient understanding of diagnosis

It was found in the study that most of the physician participants responded that the patients already know their diagnosis when they encounter them because they work in a tertiary hospital. They supported this by explaining that most patients come through referral after the initial diagnosis has been made somewhere else. This explains the gaps in communication that plays a significant role in patients' understanding of the illness.

"So, in Black lion, what we deal with is who come through a lot of referral hospitals, general hospitals, they have been told about their illness many times."BLR3

Some of the participant in the study explained that they ask the patients to understand the patients' understanding of the clinical condition. These physicians explained that they encounter patient who have no idea about their clinical condition or treatments. One of the physicians explained his surprise the time he encountered a cancer patient did not know was taking chemotherapy.

"I just ask them what do they expect or how are they going to deal if it comes positive. … They don't know what they have. A patient who has an advanced malignancy, stage four CA, does not know he is taking chemo. They don't even know they are on palliative care. They don't know. They think they are going to be cured. It means you see a lot like this."

The study found that an existing delay in patients understanding of the illness that resulted from absence of a clear communication from the health care provider. Most of the participant patients in the study explained that they did not have any knowledge about the illnesses at the time of diagnosis. They further explained it that they didn't come to learn about the illness far after the time of diagnosis because most of the physicians don't like to explain.

"I don't know anything … What they told me is that it is just red blood cell thing … How they told me, some of them just don't explain it to you … The illness gets written timely, me, I read … mostly I have doctor friends, I copy it and take it to them " BLCC5

At the same time the study found some patients that explained that they do understand their illness. The patients explained this by mentioning that they listen to their physicians, actively ask others, read about it, and follow the recommendations to increase their chances of survival. One patient illustrated this by describing how he sought information and understood the gravity of his condition through active engagement.

"A Just at first I googled it immediately after he told me. About this cancer and chemo … About the illness, I understand the medication is difficult; its cure rate, and that it can precipitate it. I understood that chance for live or death is 50 50 … And cancer when it stays long it is difficult and its chance to kill is high" BLCC

9. Discrepancy between patient information needs and provider perceptions

We found in the study that most of the participant physicians explained the existence of the need for information from the patients. They mentioned that most of the time patients ask about the illness and majority of their concern is regarding cure and survival even in dire critical conditions. This brings to light patients need for reassurance and clear information from health care providers. One physician noted:

"Usually they will ask something. What they ask you most of the time is if he will survive. It is a difficult question …. Even if he is like in critical care setting, they want you to tell them he is going to make it. Like he is going to live" BLR2

Most of the participant patients explained they constantly have the need to find more information about their illness but it is not provided to them. One cancer patient explained how his threatening to leave the hospital resulted in him finding out about his illness. This implies the need for a more proactive communication strategy.

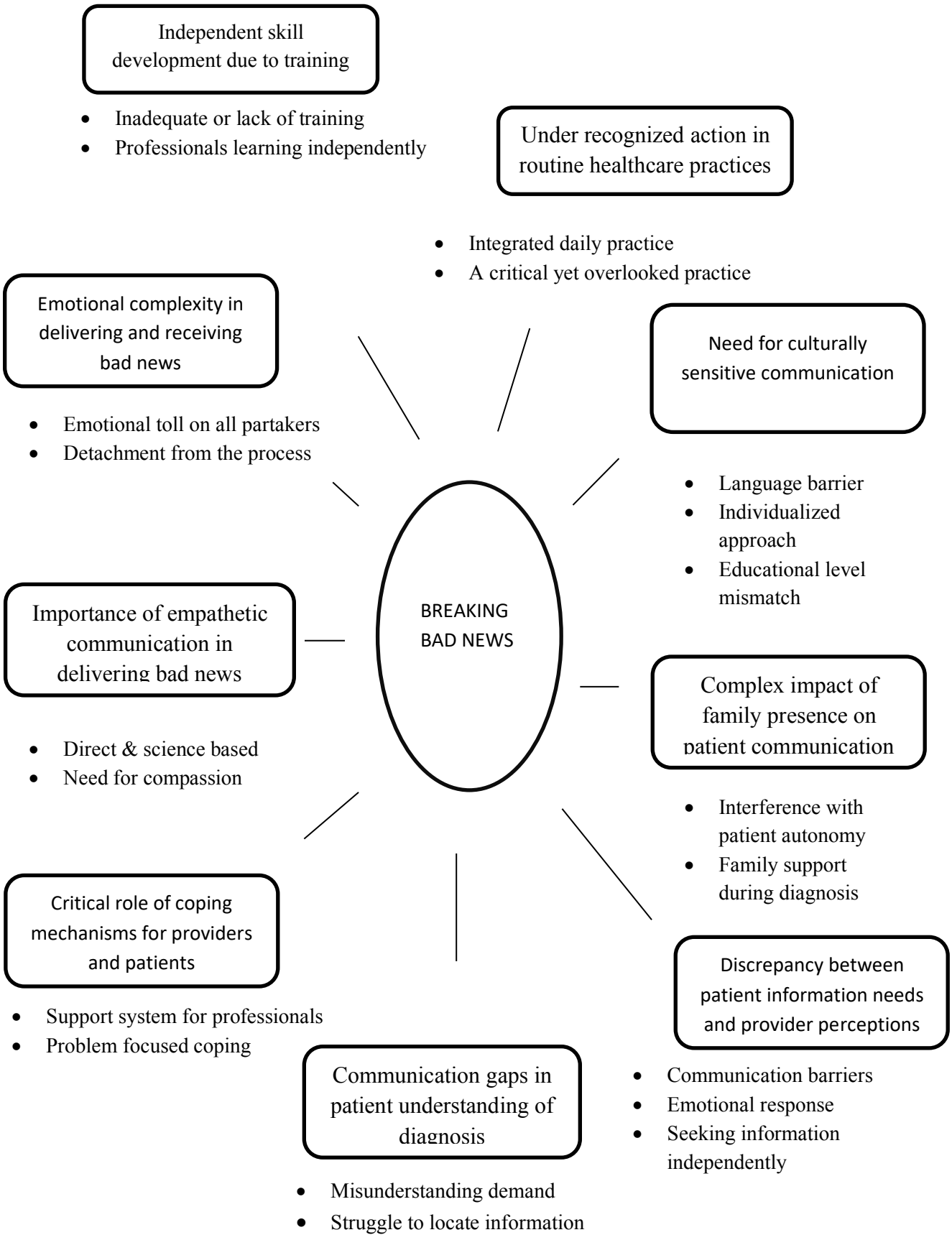
"I told them if they don't tell me my illness I won't stay on the bed because there was no reason." BLCC3

Some of the health care providers explained that patients do not have any need for information and they don't ask. This perception may indicate a disconnect between patient needs and provider awareness, emphasizing the importance of having open communication channels. One provider stated:

"You know most of our people, they do not inquire …. Meaning how I understand it. Unless we push them to ask, I haven't seen them ask me a question, most of the time. They just accept everything" BLI3

The study found that something that goes with the physicians' perspective where some patient participants mentioned that they did not ask any information about the illness at the time of the diagnosis. This can be due to many factors with one as most mentioned that they just went their way to find an answer but one of them said he was too emotional to ask any question.

"Nothing, I was shocked. It didn't come to me to talk." BLCC1


Independent skill development due to training
Inadequate or lack of training
Professionals learning independently
Under recognized action in routine healthcare practices
Integrated daily practice
A critical yet overlooked practice
Emotional complexity in delivering and receiving bad news
Emotional toll on all partakers
Detachment from the process
Need for culturally sensitive communication
Language barrier
Individualized approach
Educational level mismatch
BREAKING BAD NEWS
Importance of empathetic communication in delivering bad news
Direct & science based
Need for compassion
Complex impact of family presence on patient communication
Interference with patient autonomy
Family support during diagnosis
Critical role of coping mechanisms for providers and patients
Support system for professionals
Problem focused coping
Discrepancy between patient information needs and provider perceptions
Communication barriers
Emotional response
Seeking information independently
Communication gaps in patient understanding of diagnosis
Misunderstanding demand
Struggle to locate information

6. Discussion

Breaking bad news to patients is a challenging task for healthcare professionals, requiring not only the delivery of difficult information but also emotional sensitivity and adherence to established protocols. This and previous studies underscore the complexity of this practice, revealing overlapping concepts and challenges that healthcare professionals and patients face.

This study corroborates findings from previous research, highlighting a critical gap in the training of doctors for breaking bad news (BBN) and adherence to the SPIKES protocol. Participants reveal that only 56.3% of doctors report receiving formal education in these areas, and many lack awareness of effective communication practices (2). The necessity of self-directed learning through clinical practice emerges due to inadequate formal training during their medical education. For example, one participant noted that training is often limited to theoretical knowledge and difficult to apply in practice. This issue is not isolated, aligning with other studies that have identified a similar inadequacy of training in developing countries like Sudan and Ethiopia (9). Addressing these gaps could significantly improve adherence to communication protocols.

Communication barriers that hinder effective delivery of bad news are common findings from this current study and the studies we investigated prior. Some of the studies explain how unmet communication needs and linguistic barriers can lead to unfavorable emotional reactions (14, 17). This qualitative study expands on this by revealing that many professionals rely on delivering facts but lack the sensitivity required to support patients emotionally. Additionally, it supports this finding further by explaining how patients often find communication inadequate, citing insufficient explanation and medical jargon. One of the studies done on communication preference in patients with brain tumor, face-to-face communication and active listening were found crucial, with a preference for individualized approaches (17). However, in practice, in this study, some patients explained that they feel the delivery of bad news remains rushed and impersonal. Therefore, comprehensive communication training that prioritizes empathy, and language simplicity is needed to overcome these barriers.

One study identifies emotional challenges for clinicians when delivering bad news, with doctors experiencing depression or anxiety following disclosure (9). This study echoes this with

participants expressing emotions ranging from sadness to feeling depressed and disturbed after multiple instances of BBN. Conversely, the study also identified some clinicians viewing BBN as a routine part of their job that does not significantly affect them. Regarding patients the study mentioned also shows that patients experience significant emotional distress when receiving bad news, leading to shock or denial (9). This resonates with patient experiences in this qualitative study, where emotions like anger, disbelief, and sadness were reported. Providing emotional support for both healthcare professionals and patients could alleviate some of these challenges.

Engaging patients and families is crucial in BBN practices. In one study it was put that many patients prefer direct communication, although with limited caregiver involvement (24)**.** However, this qualitative study indicates that family members often interfere in the process by requesting professionals to withhold information from patients. A study that emphasizes on the importance of patient autonomy in these situations stated that face-to-face communication with minimal caregiver presence is often preferred (17). On the contrary in our study both clinicians and patients still acknowledged the value of family involvement for providing emotional support. Addressing these conflicting preferences requires sensitive negotiation that respects cultural norms while prioritizing patient needs.

The need for coping mechanisms among health professionals in delivering bad news is very well recognized. A study done to investigate the emotional toll of breaking bad news on physicians it was found that it provokes a significant emotional distress on them (21). In this study we found that there is a significant importance of support systems for health professionals that help them build resilience through the years of practice.

Studies show that unmet informational needs can lead to emotional distress and treatment discontinuation (14, 17). This was supported by a finding in this study when many patients described their struggles to obtain information, feeling compelled to demand answers from their physicians, or even proactively seeking information through reading and consultation with friends because they didn’t feel compelled to ask.

7. Conclusion

This study reveals the complexities and emotional challenges associated with breaking bad news (BBN) to patients with chronic illnesses. It underscores significant gaps in the formal training of healthcare professionals, leading to difficulties in adhering to established protocols and effectively communicating sensitive information. Clinicians tend to deliver facts directly but often lack the empathetic sensitivity required, resulting in cultural and linguistic barriers that leave patients confused and distressed. Both patients and professionals experience significant emotional impacts, with patients feeling shock, disbelief, or anger and clinicians experiencing sadness and stress. Despite these challenges, some clinicians view BBN as routine. Navigating patient autonomy alongside family involvement requires sensitive negotiation to respect cultural norms while prioritizing patient needs.

The study emphasizes that improving BBN practices necessitates comprehensive training programs that focus on empathy, cultural sensitivity, and coping strategies. Support systems for clinicians and patients should be enhanced to mitigate the emotional toll of delivering and receiving distressing news. These steps are crucial to ensure the delivery of bad news is handled with greater care, compassion, and adherence to protocols, ultimately enhancing the overall experience for everyone involved.

8. Recommendation

- Researchers
  - To conduct research on various training and support models, especially involving a wider range of institutes, analyze its impact further, and inform policy makers and stakeholders.

- Ministry of Health, Ministry of Education, and Medical Schools
  - Develop comprehensive training programs that emphasize communication strategies for delivering bad news. This includes teaching empathy, adherence to the SPIKES protocol, and addressing linguistic and cultural barriers.
  - Develop clear guidelines that facilitate patient-centered communication while balancing family involvement and patient autonomy.

- Healthcare Facilities
  - Establish support systems for healthcare providers, such as peer support groups or counseling services, to help manage the emotional toll and improve coping mechanisms.
  - Provide easy-to-understand educational materials to patients to ensure information accessibility about their conditions and treatment options.

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10. Appendixes

Codebook

s.no	Category	Code	Definition of code
1	Under recognized action in routine healthcare practices	Importance of breaking bad news	The acknowledgement of the significance of communicating difficult or life-changing information to patients or their families.
		Role expectations and responsibilities	The expectations and responsibilities assigned to healthcare providers based on their level of training and position within the medical hierarchy.
		First/ bad experiences	Initial encounter with delivering difficult news to a patient or their family, highlighting the circumstances and emotions involved.
		Frequency of experiences	How often the health professional encounters situations requiring the communication of bad news in their professional role.
		Good experiences	Instances where the process of delivering difficult news results in positive outcome, such as understanding, acceptance, or gratitude from recipients.
2	Independent skill development due to training gap	Training and education on breaking bad news	Individual's exposure to formal or informal training regarding the delivery of difficult news to patients or their families.
		Professional development and support	Describes the need for support to better equip healthcare providers in delivering bad news by the senior physicians.
3	Importance of empathetic communication in delivering bad news	Individualized approaches	The need for tailoring the process of delivering bad news to the unique circumstances, preferences, and cultural backgrounds of patients, and families.
		Emphasis on compassion and communication	The importance of empathy, sensitivity, and effective communication skills in the delivery of difficult news in health care settings.
		Providing hope and positive framing	Communication approach where healthcare providers focus on delivering news in a manner that emphasizes optimism and possibility, regardless of the

			clinical situation.
		Perceived insensitivity of communication	Unpleasant encounters or situations during medical care
		Approach to delivering news	How healthcare providers approach the task of delivering bad news including the preparation and the communication process
		Disclosure practices	Interaction between patients and healthcare providers during discussion about diagnosis and treatment. Instances where the information about a diagnosis was disclosed (or not disclosed) in ways that impact patient understanding and emotional response.
		Moment of diagnosis	The specific time or situation when patient receives the diagnosis.
		Setting and environment	The physical location and the emotional mood ideal for delivering serious, often distressing news to patients or their families in a healthcare setting.
		Communication barrier	Obstacles that hinder effective communication between the doctor and patient.
4	Complex impact of family presence on patient communication	Patient and family dynamics	The presence of family members or loved ones at the time of diagnosis
		Family dynamic during health communication	The interaction and relationship between patients, their families, and healthcare professionals during the communication of bad news.
		Patient autonomy and rights	Reflections or experiences related to the patient's right to information and their autonomy in the health care process.
5	Need for culturally sensitive communication in healthcare	Cultural and contextual factors	Influence of cultural beliefs in health care settings on the approach to breaking bad news.
		Cultural and educational sensitivity	Tailoring healthcare communication to align with the patient's cultural background and educational level.
6	Emotional complexity in delivering and receiving bad news	Impacts	How the act of delivering bad news affects emotional well-being or mental state of the individual responsible for communication
		Emotional reaction	The emotional response of patients to

			medical news or situations.
		Patient and family reaction	All references to how patients and their family members respond to the communication of bad news.
7	Critical role of coping mechanisms for providers and patients	Coping mechanism and adaptation	How the patient copes with or adapts to their diagnosis and treatment, including emotional coping strategies.
		Support systems for health care professionals	Resources available to healthcare professionals to cope with stress associated with breaking bad news.
8	Communication gaps in patient understanding of diagnosis	Perceived patient's understanding of the illness	Healthcare provider's assessment of the patient's level of comprehension regarding their medical condition.
		Understanding of the illness	Patients' comprehension of their medical condition and treatment options.
9	Discrepancy between patient information needs and provider perceptions	Patient information needs	Patient statements regarding their needs or desires for more information or understanding of their condition.
		Perceived patient desires	Health care provider's understanding and interpretation of a patient's desires and expectations regarding a serious medical information.
		Support post- news delivery	Instances where healthcare providers discuss the measures they take to support patients after breaking bad news.

English information sheet

Title: Breaking bad news: experience of health professionals and newly diagnosed patients with chronic illnesses in teaching hospitals of Addis Ababa

I would like to thank you for considering participation in this research. Before you decide you need to understand the purpose of the study and why your participation is important. Feel free to ask any question and please read thoroughly.

Purpose of the study and who am I

I _____ am a researcher who has an aim of understanding the practices around breaking bad news. This research aims to understand the practice and experience of health care providers towards breaking bad news and experience of patients of first time diagnosis of a chronic illness.

What does taking part mean?

For physicians taking part means participating in an interview with the researcher to give information on personal approach, practice, and experience regarding breaking bad news. The interview includes questions that are related to the practice and healthcare professional's personal experience related to the subject.

For patients taking part means participating in an interview to share personal experience during the first time of diagnosis

Why are you selected?

You have been selected as you are a health care professional in a referral hospital in Addis Ababa working with patient with chronic illness.

You have been selected because we identified you have been diagnosed with _____ (the diagnosis) in the past one month.

Is participation mandatory?

Participation in this study is completely voluntary and you can withdraw at any moment.

Risks and benefits of the study

Conducting this study will identify the situation on the ground regarding breaking bad news. In the future it will help formulate a strategy that aids the process in a positive way.

The study may induce the participant to visit unpleasant past memories that may be painful to remember.

Confidentiality

All steps in this study will ensure confidentiality by collecting and retaining non anonymized data in the form of consent forms and audio recordings as part of the research process.

How is information processed and protected

All information including signed consent forms and audio recordings will be kept until graduation. Then the data, transcripts of interviews which have no participant identifying information will be kept for two years after. You are entitled to access to this information.

What happens to the result?

The result will be disseminated to important stakeholders and will be made available online for users.

For further information contact

Dr Frehiwot Tekie,

fbraer@gmail.com,

+251912040582

THANK YOU

English consent form

Consent to take part in research

I willingly consent to taking part in this research study. I am aware that even if I agree to participate right away, I can do so at any time and will not face any repercussions for doing so. I've got written explanations of the study's nature and goal given to me. I am aware that participating entails speaking with the researcher in an interview. I am aware that taking part in this study won't directly help me. I consent to having my interview recorded on audio. I am aware that any information I give will be kept private and confidential for this study. I am aware that any report on the findings of this study will not reveal who I am. I am aware that cloaked excerpts from my interview may be quoted in dissertation, conference presentation, published papers etc. I am aware that if I tell the researcher that I or another person is in danger, they might have to report this to the appropriate authorities. They will talk to me about it first, but they might have to report with or without my approval. I am aware that my interview will be recorded and kept on file for two years following the thesis defense, with all identifiable information redacted. I am aware that, as a result of the freedom of information laws, I have the right to access the information I have given at any time while it is being stored as described above. I am aware that I have the right to get in touch with any of the research participants to get more information and clarification.

Names, degrees, affiliations and contact details of researchers

Signature of research participant date

---------- ----------

I believe the participant is giving informed consent to participate in this study

---------- ----------

Signature of researcher Date

English interview guide and questions for HCPs

Interview guide for health care professionals

- Introduction to the informant
- Explain that the purpose of the study is to identify and analyze the experience of health care professionals and patients in breaking bad news
- Explain that for this project we will ask them about their profession, their responsibility and their experience associated with breaking bad news.
- Mention all information collected will be kept safe and secret. It won't use names or any other identifying information and it will only be used for research purpose.

List of English questions for health care professionals

1. Can you please introduce yourself, your profession and your current responsibility?
2. What do you think breaking bad news is?
3. What was your first experience you remember?
4. What kind of preparation technique do you do before you meet patients or relatives?
5. How do you describe your approach do you have during the process and after?
6. What kind of impact does it have on you as a person and as a health care professional?
7. How about on how you practice immediately after?
8. What kind of responses or demands have you encountered from the patient or relatives?
9. Can you explain the bad experience you encountered so far? How about good ones?
10. What kind of measures do you think should be taken to make this process easy in the future?
11. What kind of recommendations do you have for future doctors?

English interview guide and questions for patients

- Interview guide for patients
  - Introduction to the informant
  - Explain that the purpose of the study is to identify and analyze the experience of health care professionals and patients in breaking bad news
  - Explain that for this project we will ask them about their condition, their first time diagnosis and their experience associated with the disclosure.
  - Mention all information collected will be kept safe and secret. It won't use names or any other identifying information and it will only be used for research purpose.

List of English questions for patients

1. Can you please introduce yourself and what you understand about the purpose of this meeting?
2. What kind of condition do you have?
3. What was the presentation you had which led to the current diagnosis?
4. How did you find out?
5. Do you remember your emotions in that moment?
6. What was your opinion about the condition and the specific needs you had in that moment?
7. Can you describe the process of how you were told and how satisfied you were with it?
8. What is your opinion on what could be done to improve the experience for both patients and health care professionals?

Amharic information sheet

ስለ ጥናቱ መረጃ

ስለ ጥናቱ መረጃ

የጥናቱ ርዕሰ ፡- መጥፎ ዜና መስበር በአዲስ አበባ የማስተማር ሆስፒታሎች የጤና ባለሙያዎችና አዲስ የተመረመሩ ሥር ሰደድ ሕመምተኞች ልምድ

በመጀመሪያ እዚህ ጥናት ላይ ለመሳተፍ ስለተስማሙ አመሰግናለሁ። ለጥናቱ ተሳትፎ ከመጀመረዎት በፊት ስለጥናቱ ሙሉ መረጃ እና የእርስዎ ተሳትፎ ለምን እንደሚያስፈልግ እነደሚከተለው ሰለተቀመጠ በማንበብ ይረዱ። በማንኛውም ሰአት ጥያቄ ካለዎት መጠየቅ ይችላሉ።

የጥናቱ አላማ እና የጠያቂው ማንነት

እኔ _____ ተመራማሪ ስሆን አላማዬ በጤና አገልግሎት ውስጥ ያለውን የመጥፎ ዜና አሰባበር መረዳት ነው። የዚህ ጥናት አላማ የጤና ባለሙያዎች እንዴት መጥፎ ዜና እንደሚሰብሩ እና በዚህ ሂደት ላይ ያላቸውን ልምድ እና የስር ሰደድ ሕመምተኞች ለመጀመሪያ ጊዜ ያለባቸውን ህመም ሲሰሙ የነበራቸውን ልምድ መረዳት ነው።

ጥናቱ ላይ መሳተፍ እነዴት ይገለጻል

ለጤና ባለሙያዎች ጥናቱ ላይ መሳተፍ ማለት ቃለ መጠየቁ ላይ በመሳተፍ ስለ መጥፎ ዜና አሰባበር ያለቸውን አተገባበር፣ ዝግጅት፣ እና ልምድ ማጋራት ነው።

ለ ሕመምተኞች ተሳትፎ ማለት ቃለ መጠየቁ ላይ በመሳተፍ ለመጀመሪያ ጊዜ ያለባቸውን ህመም ሲሰሙ የነበራቸውን ልምድ ማጋራት ነው።

እንዴት ለዚህ ጥናት ተመረጡ

ለጤና ባለሙያ፤ አድስ አበባ በሚገኝ የማስተማር ሆስፒታል ውስጥ የስር ሰደድ ህመም የክትትል ክፍል ውስጥ ስለሚሰሩ።

ለ ሕመምተኛ፤ ባለፈው አንድ ወር ውስጥ የታወቀ _____ (ስር ሰደድ ህመም) ስላለዎት

ስለተሳትፎ ግዳጅ

ይህ ተሳትፎ ሙሉ ለሙሉ በፈቃድ የሚካሄድ እና በማንኛውም ሰአት መቆም ይችላለል።

የጥናቱ ጥቅም እና ጉዳት

ይህንን ጥናት ማካሄድ መጥፎ ዜናዎችን በተመለከተ መሬት ላይ ያለውን ሁኔታ ይለያል። ወደፊት ሂደቱን በአዎንታዊ መልኩ የሚረዳ ስልት ለመንደፍ ይረዳል።

ጥናቱ ተሳታፊው ለማስታወስ የማይፈልገው የሚያሰቃይ፣ ደስ የማይሉ እና ያለፈ ትውስታዎችን እንዲጎበኝ ሊያነሳሳው ይችላል።

ሚስጢራዊነት

ሚስጢራዊነት በዚህ ጥናት ውስጥ ያሉ ሁሉም ሂደቶች ውስጥ ይከበራል። ይሄም ስም-አልባ መረጃዎችን በመሰብሰብ ይካሄዳል።

የተገኘው መረጃ እንዴት ይጠበቃል እንዴትስ ይቀነባበራል

ሁሉም የተገኘ ጥሬ መረጃ ከተፈረመው የስምምነት ቅጽ ጋር እስከ ምርቃት ድረስ ተመራማሪው ጋር ይቆያል። ከምርቃት በሁዋላ ለ ሁለት አመት የተተረጎመው እና ግልባጭ ስም የሌለው መረጃ ተመራማሪው ጋር ይቆያል። ተሳታፊው በነዚህ ጊዜያት የራሱን መረጃ ማግኘት ይችላል።

የውጤቱ ዕጣ ፈንታ

ውጤቱ አስፈለጊ ለሆኑ ባለድርሻ አካት ይሰርጫል እና ለተጠቃሚዎች በተለያዩ ድህረገጾች ላይ ይለቀቃል።

ለማንኛው ተጨማሪ መረጃ

ዶ/ር ፍሬህይወት ተክኤ፣ ,fbraer@gmail.com, +251912040582

ከምስጋና ጋር

Amharic consent form

የፍቃድ ቅፅ

በምርምር ውስጥ ለመሳተፍ ፈቃድ

በዚህ የምርምር ጥናት ውስጥ ለመሳተፍ ፈቃደኛ ነኝ። ምንም እንኳን ወዲያውኑ ለመሳተፍ ብስማማም በማንኛውም ጊዜ ማድረግ እንደምችል እና ይህን በማድረጌ ምንም አይነት ጥፋት እንደማይደርስብኝ አውቃለሁ። ስለ ጥናቱ ተፈጥሮ እና ግብ የተሰጡ ማብራሪያዎች በጽሁፍ ተሰጥተውኛል። መሳተፍ ከተመራማሪው ጋር በቃለ መጠይቅ መነጋገርን እንደሚጨምር አውቃለሁ። በዚህ ጥናት መሳተፍ በቀጥታ እንደማይረዳኝ አውቃለሁ። ቃለ መጠይቁን በድምጽ እንዲቀረጽ ተስማምቻለሁ። እኔ የምሰጠው ማንኛውም መረጃ ለዚህ ጥናት ሚስጥራዊ እንደሚሆን አውቃለሁ። በዚህ ጥናት ግኝቶች ላይ የትኛውም ዘገባ እኔ ማን እንደሆንኩ እንደማይገልፅ አውቃለሁ:: ከቃለ መጠይቁዬ ውስጥ ካባውን የያዙ ጥቅሶች በመመረቂያ ፅሑፍ፣ በኮንፈረንስ አቀራረብ፣ በታተሙ ጽሑፎች ወዘተ ሊጠቀሱ እንደሚችሉ አውቃለሁ። ለተመራማሪው እኔ ወይም ሌላ ሰው አደጋ ላይ እንዳለን ብናገር ለሚመለከተው አካል ማሳወቅ እንደሚኖርባቸው አውቃለሁ። መጀመሪያ ስለ ጉዳዩ ያናግሩኛል፣ ግን ከእኔ ፈቃድ ጋር ወይም ያለ እኔ ፈቃድ ሪፖርት ማድረግ አለባቸው። ቃለ ምልልሴ ከምርቃት በኋላ ለሁለት አመታት እንደሚመዘገብ እና ሁሉም ማንናት የሚገልጹ መረጃዎች ተስተካክለው እንደሚቆዩ አውቃለሁ። ምክንያት የሰጠሁትን መረጃ በማንኛውም ጊዜ ከላይ እንደተገለፀው በሚከማችበት ጊዜ የማግኘት መብት እንዳለኝ አውቃለሁ። የበለጠ መረጃ እና ማብራሪያ ለማግኘት ከማንኛውም የምርምር ተሳታፊዎች ጋር የመገናኘት መብት እንዳለኝ አውቃለሁ።

የተመራማሪዎች ስሞች፣ ዲግሪዎች፣ እና አድራሻ ዝርዝሮች

የተሳታፊ ፊርማ ቀን

ተሳታፊው በዚህ ጥናት ለመሳተፍ በመረጃ ላይ የተመሰረተ ስምምነት ሰጥቷል

የተመራማሪ ፊርማ ቀን

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Amharic interview guide and questions for HCPs

ቃለ መጠይቅ መመሪያ እና ጥያቄዎች

የጤና ባለሙያዎች የቃለ መጠይቅ መመሪያ

• መረጃ ጠያቂው እራሱን ማስተዋወቅ

• የጥናቱ አላማ የጤና አጠባበቅ ባለሙያዎችን እና ህሙማንን በመጥፎ ዜናዎች ላይ ያላቸውን ልምድ በመለየት ለመተንተን እንደሆነ ማስረዳት።

• ለዚህ ፕሮጀክት ስለ ሙያቸው፣ ስላላቸው ኃላፊነት እና ከመጥፎ ዜናዎች ጋር በተያያዘ ስላላቸው ልምድ እንደምንጠይቃቸው ማስረዳት።

• ሁሉም የተሰበሰቡ መረጃዎች ደህንነታቸው የተጠበቀ እና ሚስጥራዊ ይሆናሉ። ስሞችን ወይም ሌላ መለያ መረጃን አይጠቀምም እና ለምርምር ዓላማ ብቻ ጥቅም ላይ እንደሚውል ማስረዳት።

አማርኛ ጥያቄዎች ለ ጤና ባለሙያዎች

እባክዎትን እራስዎትን፣ ሙያዎትን እና አሁን በዚህ ሆስፒታል ያልዎትን ሀላፊነት ቢገልጹልን?

መጥፎ ዜና መስበር የሚለውን ሀሳብ እንዴት ይረዱታል?

የሚያስታውሱት ለመጀመሪያ ጊዜ ያለዎትን ለምድ እና በምን ያህል ድግግሞሽ እንደሚተገብሩት እስቲ ይግለጹልን?

ምን አይነት ቅድሚያ ዝግጅት ያደርጋሉ?

በተግባሩ ጊዜ ምን አይነት ስልት ይጠቀማሉ፣ ከጨሱ በሁዋላስ?

እንደ አንድ የሰው ልጅ እና አንድ የጤና ባለሙያ ምን ያህል ተጽዕኖ አሳድሮብገኛል ብለው ያምናሉ?

ድርጊቱን እንድጨረሱ ስራዎት ላይስ?

ከታካሚ ወይም ከ ቤተሰቦቻቸው ምን አይነት ጥያቄ እና መልስ ተዘውትሮ ይታያል?

መጥፎ ወይም ጥሩ የሚሉት ልምድን ቢያካፍሉን?

ምን አይነት እርምጃ ቢወሰድ ይህን ተግባር ማሻሻል ይቻላል ብለው ያምናሉ?

ለወደፊት ለሚመጡ ተመራቂ ጤና ባለሙያዎች ምን ይመክራሉ?

Amharic interview guide and questions for patients

ለታካሚዎች የቃለ መጠይቅ መመሪያ

• መረጃ ጠያቂው እራሱን ማስተዋወቅ

• የጥናቱ አላማ የጤና አጠባበቅ ባለሙያዎችን እና ህሙማንን በመጥፎ ዜናዎች ላይ ያላቸውን ልምድ በመለየት ለመተንተን እንደሆነ ማስረዳት።

• ለዚህ ፕሮጀክት ስለ ሁኔታቸው፣ ለመጀመሪያ ጊዜ ምርመራቸው እና ከመግለጫው ጋር ተያይዞ ስላላቸው ልምድ እንደምንጠይቃቸው ያብራሩ።

• ሁሉም የተሰበሰቡ መረጃዎች ደህንነታቸው የተጠበቀ እና ሚስጥራዊ ይሆናሉ። ስሞችን ወይም ሌላ መለያ መረጃን አይጠቀምም እና ለምርምር ዓላማ ብቻ ጥቅም ላይ እንደሚውል ማስረዳት።

ለታካሚዎች የአማርኛ ጥያቄዎች ዝርዝር

1. እባክዎ እራስዎን እና ስለዚህ ስብሰባ አላማ የምትረዱትን ማስተዋወቅ ይችላሉ?

2. ምን አይነት ሁኔታ አለዎት?

3. ለአሁኑ ምርመራ የደረጋችሁ አቀራረብ ምን ነበር/የመጀመሪያ ምልክት?

4. ምን አይነት ህመም እንደሆነ እንዴት አወቁ?

5. በዚያ ቅጽበት የነበረዎትን ስሜት ያስታውሳሉ?

6. ስለ ሁኔታው እና በዚያ ቅጽበት ስለነበረዎት ልዩ ፍላጎቶች እና የነበረዎት አስተያየት ምን ነበር?

7. የተነገሩበትንን ሂደት እና ምን ያህል እርካታ እንደሰጠዎት መግለፅ ይችላሉ?

8. ለሁለቱም ታካሚዎች እና የጤና እንክብካቤ ባለሙያዎች ልምድ ለማሻሻል ምን መደረግ እንዳለበት አስተያየትዎ ምንድ ነው?