

**PHYSICIAN'S ATTITUDE AND PRACTICE TO DISCLOSURE OF CANCER
DIAGNOSIS TO PATIENTS IN JOS UNIVERSITY TEACHING HOSPITAL NORTH
CENTRAL NIGERIA**

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ABSTRACT

Background: As the prevalence of malignancies increases worldwide in general and in Nigeria in particular, clinicians are faced with the responsibility of disclosing life altering information to their patients about cancer. How this is disclosed often has implications on subsequent management.

Objectives: The aim of this study was to assess the attitude and practice of clinicians in Jos University Teaching Hospital on disclosure of cancer diagnosis to patients.

Methods: This was a cross-sectional study of 169 clinicians across 9 clinical departments practicing in Jos University Teaching Hospital (JUTH) between April to May 2017. The responses on attitude and practice were scored based on a six step SKIPES protocol on delivering bad news. A minimum sample size of 100 was calculated but increased to 150 to compensate for non-responders. The questionnaires were administered at duty posts of doctors. Simple percentages were used to describe responses on attitude and practice and Fisher's exact test was used to analyze contingency tables. The data were analyzed using SPSS version 16.0. A p value of 0.05 was used to test for significance.

Results: Most of the respondents were clinicians in the departments of Surgery 37(21.9%) and Obstetrics and Gynaecology 35(20.7%). Registrars were in the majority in the responders (55%), senior registrars were 26% and consultants made up 18.9% of the respondents. The mean age of respondents was 36.90±6.68, 77% of the respondents frequently treated malignancies while 55% treated malignancies occasionally and 2.4 % had never treated malignancies. 99.4% felt patients should be informed about a diagnosis of cancer before treatment and 69.8% felt it was the responsibility of the managing consultant to disclose cancer diagnosis to patients while 30.2% felt senior registrars should do so. Nearly 80%(78.1%)felt they were capable of disclosing cancer diagnosis yet a majority (88.8%) felt they required training on breaking of bad news to patients with a significant number of those who felt they required training on breaking of bad

news were under 50 years of age $p=0.012$. More of the disclosure (56.8%) was done at bedside and 43.2% was in the clinic.

Conclusion: Physician's attitude and practice of the protocols for disclosure of cancer diagnosis were generally satisfactory but a statistically significant number under the age of 50 years acknowledged their need for additional training on this skill.

Key words: attitude, practice, Cancer diagnosis

Introduction

Breaking the bad news of a diagnosis of cancer in the face of late presentation commonly witnessed in Nigeria and an often-bleak prognosis is a daunting task for most doctors. It is however a necessary part of the management process to elicit the consent and cooperation of a patient in developing treatment strategies. Bad news is defined as "any information which adversely and seriously affects an individual's view of his or her future".¹ The diagnosis of a malignancy therefore is bad news and a life changing event.

Communication related to the diagnosis of cancer is a complicated matter that transcends a mere transfer of facts. Many patients come with their own belief systems and preferences influenced by family and care givers with peculiar cultures that need to be factored in the process of disclosure.²

Disclosure can either facilitate therapeutic bonding between the doctor and the patient or worsen it. Adverse outcomes for example have been described in patients with gastrointestinal and lung malignancies with increased pain scores and poor physical and emotional functioning after disclosure was done poorly but handled competently, patients suffering

from breast cancer had reduced long term emotional distress and physical well-being.^{3,4} Studies on cancer patients in Nigeria show that over 50% wish to know the truth about their diagnosis even when the disease is terminal or advanced.⁵

Meeting the desire of patients to know their diagnosis requires a physician to move beyond a mere statement of the diagnosis and includes responding to emotional reactions, dealing with a patient's expectations for possible cure, dealing with stressed family members and having to cope with situations where the intent of treatment may be only palliative. This often makes such interactions an avenue for miscommunication, with attending physicians, patients and family members having different expectations about outcomes.^{6,7}

Protocols vary for the breaking of bad news but the 6 step strategy SPIKES protocol that this study was based on requires that the clinician arranges for some privacy, mentally rehearses the plan for telling the patient and preparing for emotional reactions or difficult questions. Significant family members are also invited and the patient's perception about the illness itself is assessed before information on the diagnosis is shared.⁸

This aim of this study is to describe the attitude and practice of clinicians in JUTH regarding this skill during an increasing prevalence of cancers in Nigeria.

MATERIALS AND METHODS

This was a descriptive cross section study carried out at the Jos University Teaching hospital (JUTH) a tertiary hospital in North Central Nigeria. The hospital serves as a referral center of the neighbouring states of Benue, Bauchi and Nasarawa. The study was carried out over a 4-week period between April and May 2017. A structured, closed end questionnaire was administered to doctors at clinics and other duty posts regarding their attitude and practice of disclosure of cancer diagnosis to patients. Ethical clearance was obtained from the Ethics Committee.

Statistical analysis

Analysis of data was carried out using (IBM corporation Mac OS, linux and unix 2015 version 22). Results were presented in tables and figures and figures as percentages. Statistical significance was calculated using Chi-square test with the level of significance set at $p\text{-value} < 0.05$.

RESULTS

The mean age of respondents was 36.90 ± 6.68 . Respondents were mostly between ages 30-39 (69.2%), Male participants were $n = 132$

(78.1%) and 36 were female (21.3%).

Respondents cut across different departments, varying from surgery (21.9%) to Heamatology (3.0%). (Table 1)

Clinicians in the departments of Surgery 37(21.9%) and Obstetrics and Gynaecology 35(20.7%) were in the majority. Registrars were in the majority in the responders (55%), senior registrars were 26% and consultants made up 18.9% of the respondents. The mean age of respondents was 36.90 ± 6.68 .

77% of the respondents frequently treated malignancies while 55% treated malignancies occasionally and 2.4 % had never treated malignancies. 99.4% felt patients should be informed about a diagnosis of cancer before treatment and 69.8% felt it was the responsibility of the managing consultant to disclose cancer diagnosis to patients while 30.2% felt senior registrars should do so. 78.1% felt they were capable of disclosing cancer diagnosis yet a majority (88.8%) felt they required further training on breaking of bad news to patients with a significant number of those who felt they required training on breaking of bad news were under 50 years of age $p = 0.012$. Regarding actual practice, 57.4% of the respondents said consultants occasionally delegated this duty to others while 22.5% stated that this was a frequent practice. Most of the respondents did disclosure of cancer diagnosis at bedside (56.8%) and 43.2% disclosed cancer diagnosis in the clinic. (Table 3)

Table 1: Demographic characteristics of physicians

Characteristics	Frequency	Percent	Mean (±Std.Dev)
Age			
<30	10	5.9	37.0±6.9
30-39	117	69.2	
40-49	33	19.5	
≥50	9	5.3	
Sex			
Male	132	78.1	
Female	36	21.3	
Missing	1	0.6	
Cadre			
Consultant	32	18.9	
Senior Registrar	44	26.0	
Registrar	93	55.0	
Specialty			
Surgery	37	21.9	
Obstetrics and Gynaecology	35	20.7	
Internal medicine	25	14.8	
Pediatrics	25	14.8	
Family medicine	11	6.5	
Ophthalmology	14	8.3	
ENT	9	5.3	
Orthopedic	8	4.7	
Haematology	5	3.0	
Years of Practice			
≤5	42	24.9	8.9±6.0
6-10	92	54.4	
11-15	16	9.5	
16-20	8	4.7	
≥20	11	6.5	
Treatment of patients with malignancies			
Never	4	2.4	
Occasionally	90	53.3	
Frequently	75	44.4	

Table 2: Physicians Attitude towards disclosure of cancer diagnosis

Attitude	f	%
Do you feel patients diagnosed with cancer should be informed about their diagnosis		
Yes	168	99.4
No	1	0.6
if yes, when do you consider the ideal time to disclose the diagnosis		
Immediately after confirmation of diagnosis	112	66.3
Before commencement of treatment	6	3.6
Earliest opportunity before discharge	3	1.8
After histological confirmation	48	28.4
Under which condition will you not disclose the diagnosis to the patient		
Patient not in good state of mind	110	65.1
Patient has a mental impairment	59	34.9
Why do you think it is important to disclose the diagnosis to patient		
It is the right of the patient to know	135	79.9
To carry out the treatment under patients understanding	34	20.1
Who do you feel should inform the patient about the diagnosis		
Consultant	118	69.8
Senior Registrar	51	30.2
Do you feel capable of disclosing the diagnosis of cancer to your patient		
Yes	132	78.1
No	8	4.7
Not sure	29	17.2
Where is the ideal location you would discuss the diagnosis of cancer with your patient		
Bed side	35	20.7
Clinic appointment	134	79.3
Would you disclose the diagnosis to the family members first before disclosure to the patient		
Yes	20	11.8
No	149	88.2
What is your opinion about involving family members during the disclosure of a diagnosis of cancer		
Necessary	120	71.0
Not Necessary	49	29.0
Do you feel you require training in breaking bad news to your patients		
Yes	150	88.8
No	12	7.1
Not sure	7	4.1

Table 3: Physicians practice towards disclosure of cancer diagnosis

Statements on Practice	f	%
Who handles the disclosure of the diagnosis of cancer in your unit		
Consultant	131	77.5
Senior Registrar	38	22.5
In your experience, does the managing consultant delegate disclosure of cancer diagnosis to other persons		
Occasionally	97	57.4
Frequently	38	22.5
Never	15	8.9
Not sure	19	11.2
Have you ever treated a cancer patient before disclosure		
Yes	24	14.2
No	145	85.8
What preparations would you carry out before disclosure		
Know the facts	154	91.1
Ensure privacy	15	8.9
In your practice do you treat patients with malignancies		
Occasionally	92	54.4
Frequently	74	43.8
Never	3	1.8
On average how many patients with malignancies do you treat in a year		
none	32	18.9
1-10	89	52.7
11-20	27	16.0
21-30	8	4.7
31-40	7	4.1
>40	6	3.6
When you disclosed a diagnosis of cancer to a patient where was it done		
Bed side	96	56.8
Clinic appointment	73	43.2
Do you routinely check for your patients understanding after disclosure of cancer diagnosis		
Often	95	56.2
Occasionally	74	43.8
When ready to tell this patient about the diagnosis, how would you approach it		
Straight out with the diagnosis as it is	31	18.3
Fire a warning shot "i am afraid it looks rather serious"	138	81.7
Having disclosed the diagnosis, your patient is in denial and doesn't believe it's true. How would you handle this		
Insist on explaining the diagnosis	34	20.1
Let the patient control amount of information given	135	79.9
Having disclosed the diagnosis, what is the next step you will take		
Prepare for treatment	22	13.0
Allow the patient to mention her concern	147	87.0
The patient starts crying and becoming emotional, how would you handle this		
Ask patient to stop crying	5	3.0
Find a way to end the session	164	97.0
The counseling for disclosure of diagnosis has come to an end, would you routinely summarize the discussions		
Yes	109	64.5
No	18	10.7
Occasionally	42	24.9

DISCUSSION:

In this study, the demographic characteristics of the respondents are shown in Table 1, illustrate that over half of the respondents were clinicians in the surgical departments with registrars being the most numerous cadres of doctors. Most of the respondents had managed patients with cancer, 53.4% managed cancer patients occasional and 44.4% did so frequently.

99.4% of the study participants felt that patients should be informed about a diagnosis of cancer prior to commencement of treatment (Table 2). This conforms with correct practice as described in most protocols but the practice of disclosing cancer diagnosis at patient's bedside by 56.8% of the respondents does not provide the level of privacy necessary for disclosure of cancer diagnosis.⁸

The design of wards in the hospital does not shield patient's from other admitted people or their caregivers and other doctors who may be attending to their own duties while not be directly involved with managing the cancer patient. Being a teaching hospital, quite often, medical students, nurses and residents may also be at the bedside of patients that require to get such information so bedside counselling is less than ideal. The challenge of office spaces in JUTH requires that physicians get more creative while discussing such sensitive information with their patients. 71% of the doctors surveyed felt it was necessary to involve family care givers when disclosing cancer diagnosis. This may be consistent with needs of individual patients who often require support during the illness surrounded by family members that not only serve as care givers but pay the hospital bills.

Regarding checking for a patient's understanding of the cancer diagnosis, 56.2%

checked for understanding from the patient while 43.8% checked for understanding occasionally. (Table 3).

Other practices that were consistent with recommended protocol in the study participants included 'firing warning shots' which are exploratory statements designed to prepare a patient for bad news that will follow; 81.7% of the participants used this technique. 79.9% also stated that they allowed the patient control the amount of information he/she wanted divulged during the counselling sessions, 87% would allow patient's express their concerns after being informed of the diagnosis and 97% of respondents said they would allow patients express emotional responses like crying after hearing the diagnosis of cancer and 64.5% stated that they summarized the discussions at the end of disclosure of the diagnosis.

In spite of most responses of the participants in the study being consistent with some level of good practice, 88.8% of the respondents felt they required training in breaking bad news to patients. A similar survey in the United States identified that less than 10% of oncology physicians attending an annual meeting of the American Society of Clinical Oncology (ASCO) had formal training in breaking of bad news and only 32% observed interviews where practical demonstrations of breaking bad news were done during their trainings.⁸ The index study suggests that clinicians need additional training to make them comfortable in delivering the bad news of a cancer diagnosis. The fact that a significant number of clinicians that felt the need for further training were < 50 years of age suggests that experienced clinicians are more comfortable with this responsibility, this may explain why only 22.5% of the respondents stated that in their experience, consultants, who are usually older clinicians

delegate breaking bad news to other health personnel.

One of the few studies among patients suffering from cancer in University of Nigeria Teaching Hospital Enugu showed that while 95% of patients wished to know their diagnosis, but as much as 76.1% said their attending physicians did not provide information on the diagnosis of their ailments.⁹ In contrast, another study in India among cancer patients and their care givers showed that the patients preferred full disclosure of the diagnosis and it's prognosis ,while the family care givers preferred non-disclosure of the same.¹⁰ Most of the literature concerning disclosure practices in the literature are not centered on cancer diagnosis but explore surgeon -patient information on diseases generally but nonetheless, the findings from this study concur with findings by Ogundiran in Southwestern Nigeria that disclosure of information to patients concerning their diagnosis is suboptimal with respect to privacy and training on disclosure of information .¹¹

Where physicians are uncomfortable bearing such bad news that include the poor prognosis of cancer, strategies for coping with their own distress when such news is disclosed can increase the physician's confidence.^{12,13} It is a critical skill that needs capacity building by trained psychologists and palliative care specialists in Nigeria particularly because so many patients present at advanced stages of cancer. This finding is not peculiar to Nigeria with similar findings found in studies in the United Kingdom where physicians tend to underappreciate the need of the patient to have insight into the nature of ailments because they lack training in psychological aspects of cancer management.¹⁴

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CONCLUSION: This study shows that attitude towards disclosure protocols for patients with a diagnosis of cancer in Jos University Teaching Hospital (JUTH) was good in most medical doctors, but privacy is not maintained optimally because more than half of disclosures occur at patient's bed sides. There is a self-assessed need for more training on disclosure of cancer diagnosis by doctors in JUTH.

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