RESEARCH COMMUNICATION

Preferences of Malaysian Cancer Patients in Communication of Bad News

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Abstract

Background: Breaking bad news to cancer patients is a delicate and challenging task for most doctors. Better understanding of patients' preferences in breaking bad news can guide doctors in performing this task. Objectives: This study aimed to describe the preferences of Malaysian cancer patients regarding the communication of bad news. Methodology: This was a cross-sectional study conducted in the Oncology clinic of a tertiary teaching hospital. Two hundred adult cancer patients were recruited via purposive quota sampling. They were required to complete the Malay language version of the Measure of Patients' Preferences (MPP-BM) with minimal researcher assistance. Their responses were analysed using descriptive statistics. Association between demographic characteristics and domain scores were tested using non-parametric statistical tests. Results: Nine items were rated by the patients as essential: "Doctor is honest about the severity of my condition", "Doctor describing my treatment options in detail", "Doctor telling me best treatment options", Doctor letting me know all of the different treatment options", "Doctor being up to date on research on my type of cancer", "Doctor telling me news directly", "Being given detailed info about results of medical tests", "Being told in person", and "Having doctor offer hope about my condition". All these items had median scores of 5/5 (IQR:4-5). The median scores for the three domains were: "Content and Facilitation" 74/85, "Emotional Support" 23/30 and "Structural and Informational Support" 31/40. Ethnicity was found to be significantly associated with scores for "Content and Facilitation" and "Emotional Support". Educational status was significantly associated with scores for "Structural and Informational Support". Conclusion: Malaysian cancer patients appreciate the ability of the doctor to provide adequate information using good communication skills during the process of breaking bad news. Provision of emotional support, structural support and informational support were also highly appreciated.

Keywords: Patient preference - truth disclosure - palliative care

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Introduction

The task of disclosing bad news to patients is something many doctors find challenging and unpleasant. Commonly cited barriers include lack of time, lack of training, lack of knowledge and emotional factors including fear, guilt, and personal experiences (Dosanjh et al., 2001; Supe, 2011). Despite attempts to include communication skills into the medical curriculum, junior doctors were perceived to be inadequately trained in communication of bad news (Chan, 2012).

Guidelines on disclosing bad news were developed to aid healthcare professionals in performing the task (Baile et al., 2000). However, patients' preferences and communication needs were not always consistent with the recommendations made (Butow et al., 1996). Thus, researchers began looking into patients' preferences in this area of communication.

The Measure of Patients' Preferences (MPP) questionnaire was developed by Parker et al to explore this area (Parker et al., 2001). It consisted of 32 items which measured patients' preferences in 3 key domains, which are Content, Facilitation and Support. It has been translated and validated in various countries including Japan (Fujimori et al., 2007), Italy (Mauri et al., 2009) and Singapore (Chiu et al., 2006). A Malay language version has been developed and validated in Malaysia, and confirmed to be valid and reliable (Cronbach alpha 0.81-0.93) (Tan et al., 2012).

Studies utilizing the various language versions of the MPP have demonstrated that culture affected the patients' preferences (Fujimori et al., 2007;Mauri et al., 2009). They also found associations between demographic factors such as gender (Parker et al., 2001; Chiu et al., 2006; Fujimori et al., 2007) and educational status ((Parker et al., 2001; Mauri et al., 2009)) affected patients' preferences for the various domains measured. As there have hitherto been no such studies in Malaysia, the present study aimed to look into the preferences of Malaysian cancer patients in this regard.

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Materials and Methods

This study was conducted at an Oncology clinic of a tertiary teaching hospital with permission from the hospital's ethics committee. Two hundred adult cancer patients were recruited for this study. They were approached while awaiting their turn to be seen in the clinic. The patients were selected via purposive quota sampling based on gender and ethnicity to reflect the demographic profile of the clinic patients. Patients aged 18 years and above who had been informed regarding the diagnosis of cancer at least 1 month prior to recruitment and were Malay literate were included into the study. Patients who were unwell physically and emotionally unstable were excluded.

The Malay language version of the MPP-BM was administered to the respondents with some guidance from a researcher. The patients were asked to rate their preferences for each item based on a Likert scale of 1 to 5. (1-not important, 2-optional, 3-important, 4-very important and 5-essential, every doctor should do it). The MPP-BM was found to consistently measure preferences in 3 domains, which were "Content and Facilitation" (Cronbach alpha 0.92), "Emotional Support" (Cronbach alpha 0.81) and "Structural and Informational Support" (Cronbach alpha 0.841) (Tan et al., 2012).

The responses for each item and domain were analysed using descriptive statistics. Association with the demographic factors were then analysed using non-parametric statistical tests. IBM SPSS version 19 was used.

Results

Patients' demographics

Table 1 displays the characteristics of the patients recruited for this study. The mean age was 52.5 years. There were more female patients (62%). Most patients had only up to secondary school education. The commonest diagnoses among the samples were breast cancer (31%), colorectal cancer (16%) and nasopharyngeal carcinoma (8%). The gender ratio, ethnicity ratio and diagnosis corresponded to the Oncology clinic annual demographics. The median duration of diagnosis prior to recruitment into the study was 15 months.

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The individual scores for all items of the MPP-BM were negatively skewed as most items received a rating of 3 and above. This reflects that most items in the questionnaire were important to the respondents.

Table 2 displays the ten highest and ten lowest rate items, their median scores and inter-quartile ranges. The items which had the highest ratings from the respondents belonged to the same domain of "Content and Facilitation". They may reflect the high need for medical information by the cancer patients.

Items such as "Making me feel ok to show my emotional reaction", "Telling me it's ok if I become upset", "Doctor helps me figure out how to tell others about my condition" and "Having another health care provider present to offer support" were rated comparatively lower (median score 3/5, IQR 2-5). However, these items were considered important by the respondents to some extent. Among the three domains measured by the MPP-BM, "Content and facilitation" had the highest ratings (74/85), followed by "Structural and Informational Support" (31/40) and "Emotional Support" (23/30).

Table 1. Sample Characteristics

Characteristics (N=200)		No. of patients	Percentage (%)
Age:	Mean (sd)	52.5 years	
Gender:	Male	76	38.0
	Female	124	62.0
Ethnicity:	Malay	110	55.0
	Chinese	62	31.0
	Indian	26	13.0
	Others	2	1.0
Education:	Primary school	42	21.0
	Secondary school	110	55.0
	Diploma	29	14.5
	Degree	19	9.5
Type of cancer:	Breast cancer	62	31.0
	Colorectal cancer	32	16.0
	Nasopharyngeal carcinoma	16	8.0
	Lung cancer	12	7.5
	Cervical cancer	11	5.5
	Thyroid cancer	10	5.0
	Prostate cancer	42	21.0
	Others		
Stage of disease:	1	37	18.5
	2	69	34.5
	3	61	30.5
	4	33	16.5
Duration of diagnosis:			
	Median	15 months	

Table 2. The 10 Highest and 10 Lowest Rated Items and Their Median Scores

Questionnaire item	1-5*	IQR
Highest		
Doctor is honest about the severity of my condition	5	4-5
Doctor describing my treatment options in detail	5	4-5
Doctor telling me the best treatment options	5	4-5
Doctor letting me know all of the different treatment options	5	4-5
Doctor being up to date on research regarding my type of cancer	5	4-5
Doctor telling me news directly	5	4-5
Being given detailed info about results of medical tests	5	4-5
Being told in person	5	4-5
Having doctor offer hope about my condition	5	4-5
Doctor telling me about support services available	5	3-5
Lowest		
Having another health care provider present to offer support	3	2-5
Doctor helps me figure out how to tell others about my condition	3	2-5
Telling me it's ok if I become upset	3	3-5
Making me feel ok to show my emotional reaction	3	3-4
Having doctor inform family members about my prognosis	4	3-5
Having doctor inform my family members about my diagnosis	4	3-5
Waiting until all tests in before giving news	4	3-5
Comforting me if I become emotional	4	3-5
Having doctor tell me about resources in the community	4	3-5
Encouraging me to talk about my feelings	4	3-5

*Median score (Range:1-5).

Table 3. The Association between Ethnicity and Education Status with the Domains of the MPP

	Content and facilitation	Emotional support	Structural and informational support
Ethnicity			
Malay	71	22	29
Chinese	76	24	33
Indian	78.5	25	32.5
p	0.002	0.018	0.113
Education status			
Primary	74	24	31
Secondary	73	22	30
Diploma	69.5	21.5	28.5
Degree	71	23	26
p	0.116	0.124	0.043

*Median scores, $p<0.05$, Kruskall-Wallis test

Non-parametric statistical tests were used to compare the median scores of each domain. Ethnicity was found to be significantly associated with the scores for "Content and Facilitation" as well as "Emotional support". The Chinese and Indian respondents had higher preference for "Content and Facilitation" compared to the Malays. Educational status was found to be significantly associated with scores for "Structural and Informational Support". Respondents with lower educational status had a higher preference for "Structural and Informational Support". The median scores and p values for these domains are displayed in Table 3.

Age, gender and duration of diagnosis were not significantly associated with the scores for any domain.

Discussion

This study may reflect that Malaysians desire honesty from their doctors when it comes to communication of bad news. This is in contrast with the general perception that Asian patients should be protected from being given bad news, for fear that they would not be able to cope (Huang et al., 1999; Lapine et al., 2001). However, many studies have shown that the reverse is often true (Kumar et al., 2004; Tang et al., 2006). Honesty is an important characteristic in order for the patient to trust their doctors (Nguyen and Bellamy 2006). Honesty in communication of bad news is essential for most patients, although it would bring out unpleasant emotions. It is important for doctors to find out how much information is desired by the patient prior to disclosure.

Upon receiving the diagnosis, Malaysian cancer patients also demonstrated a desire for more information regarding their disease. The ability of the doctor to explain in detail regarding results of tests as well as the best available treatment option and alternative treatment options was viewed as essential by majority of the respondents. Therefore, prior to the disclosure of bad news, doctors should be prepared with adequate knowledge to answer any queries. The need for such information reflects their desire for hope in their situation (Hagerty et al., 2005). In fact, the ability to offer hope was another aspect of communication that was rated essential in cancer communication. The ability to break bad news well also improved hope among cancer patients and their family members regardless of their prognosis (Mack et al., 2007).

Most Malaysian people are more reserved in display of emotions (Goddard, 1997; Kim et al., 2001). Thus, it is not unexpected that expression of their emotional reaction was rated lower than other items. However, facilitating expression of emotions by the patients helped to reduce distress levels. Having the doctor to facilitate expression of emotions was therefore considered important by the respondents. In disclosing bad news, it is advisable to invite expression of emotions by the patients rather than compelling them to do so. Good rapport between the doctor and the patient would be beneficial in helping the patients to express their feelings.

Malaysian cancer patients also placed less importance on the role of the doctor in informing others regarding their diagnosis. Presence of a third party, albeit of another healthcare professional, was less preferred. Again, this is linked to the Asian culture where the family's interests are placed before others and bad news is seldom shared with non-family members (Kim et al., 2001). Malaysian cancer patients preferred to retain some degree of control over who was to be informed regarding this matter.

The role of cultural differences was suggested by the significant association between ethnicity and scores for "Content and Facilitation" and "Emotional Support". Malays tended to be more reserved in requesting for emotional support and information seeking (Goddard, 1997) However, this attitude may change as societal values evolve with time. It is recommended that in cancer communication doctors can encourage participation of ethnic Malay patients by inviting them to ask questions to ensure that their informational and emotional support needs are being met. The practice of inviting questions from patients was also recommended among Japanese cancer patients (Fujimori et al., 2007).

Patients with lower educational status required more "Structural and informational support". Thus, the ability of the doctor to direct them to the appropriate healthcare support services was greatly appreciated. They would also require help from the doctor to inform their relatives regarding their condition and treatment. By doing so, doctors can help the patient to identify their own support network.

This study is limited by the small sample size and purposive sampling method. Therefore, the results may not be generalized to the entire Malaysian population or other South East Asian populations. Nonetheless, it offers interesting insights into how culture can affect cancer patients' preferences for communication of bad news. Future studies should be conducted in multiple centres and on a larger population to confirm the association of these factors with cancer patients' preferences.

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