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Communicating bad news: attitudes and modes of communication of the health professions

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ABSTRACT. **Background**. ***Information regarding ominous prognoses, which may cause concern and distress, should be provided carefully and cautiously, using non-traumatizing terminology, accommodating the patient's fears, and not excluding elements of hope.***
Goal. ***To analyze the difficulties of health care providers in the process of communicating bad news.***
Materials and Methods. ***An observational, cross-sectional, multicenter study was conducted from March to August 2021 among Italian Physicians and Nurses.***
Results. ***The results of the study indicate a greater participation of Nurse practitioners than Physicians, a fact that may indicate how necessary it is, to overcome the belief that the communication of bad news is of exclusive medical relevance. Among the participants in the study, about half, equal to 46.7% stated that they had no specific training, while the remainder claimed to have attended master's or higher education courses in 8.5% of cases, 23% attended conferences, while 21.8% acquired their skills through work experience.***
Conclusions. ***The communication of bad news, needs to be recognized in the same way as those procedures that characterize care itself, and for which the highest possible quality is sought.***

Key words: *communication, bad news, relationship, care, knowledge.*

RIASSUNTO. **Comunicare le cattive notizie: atteggiamenti e modalità di comunicazione dei professionisti sanitari.** ***Background.*** **Le informazioni riguardanti prognosi infauste, tale (tali) da poter procurare preoccupazione e sofferenza, devono essere fornite con attenzione e prudenza, usando terminologie non traumatizzanti, accogliendo i timori del paziente e non escludere (escludendo)elementi di speranza.**
Obiettivo. **Analizzare le difficoltà degli operatori sanitari nel processo di comunicazione delle cattive notizie.**
Materiali e Metodi. **Da Marzo ad Agosto 2021 è stato condotto uno studio osservazionale, cross sectional, multicentrico, in una popolazione di Medici ed Infermieri**
Risultati. **I risultati dello studio indicano una maggiore partecipazione dei professionisti Infermieri rispetto ai Medici, un dato che può indicare quanto sia necessario, superare la convinzione che la comunicazione di una cattiva notizia sia di pertinenza esclusivamente medica. Tra i partecipanti allo**

Introduction

The communication of bad news is one of the most stressful events to deal with during the course of treatment. During this communication, a deep crisis opens up that involves, not only the patient, but also every member of the family. The person is exposed to a reality that threatens his balance, his sources of certainty and his future plans and this causes a feeling of loss, so much so that it is often experienced as a judgment, with no possibility of a way out (1). Bad news is information that determines, in the person who receives it, such suffering as to drastically and negatively alter the vision of the future. Fallow field and Jenkins (2) define it as "any information that produces a negative consequence in a person's expectations regarding his or her present and future (2). Although it is clear that only the recipient can define how "bad" a piece of news is, in general, bad news can be conceptualized as news that has as its subject matter that of death, injury, or other threats to mental and physical integrity for oneself or a significant other (3). The communication of bad news, is an aspect that brings together two fundamental and interdependent elements: communication and patient interaction. According to the recent increasingly widespread concept of teamwork, nurses have the task of supporting the patient in receiving and reacting to bad news, as well as discussing with the patient where there are doubts, considering the same, not only as a single event, but an entire process in which nursing care alongside the patient allows healthcare professionals to become a point of reference for the patients themselves, spending the most time with the patient. Therefore, nurses could not be excluded from the responsibility of communicating bad news, also favoring the continuity and overall care of the patient. Exemplar is the case concerning palliative care and the path that patients take, where the progress of the disease, the adaptation of therapies, as well as the information and preparation of what will be faced in the final stages of life, lead

studio circa la metà, pari al 46.7% ha dichiarato di non avere alcuna formazione specifica, mentre la restante parte sostiene di aver frequentato master o corsi di alta formazione nell'8.5% dei casi, il 23% ha partecipato a dei convegni, mentre il 21.8 % ha acquisito le proprie abilità attraverso l'esperienza lavorativa.
Conclusioni. **La comunicazione delle cattive notizie, necessita di essere riconosciuta alla stregua di quelle procedure che caratterizzano l'assistenza stessa, e per le quali si cerca di garantire la massima qualità possibile.**

Parole chiave: comunicazione, bad news, relazione, cura, conoscenze.

nurses to have to deal constantly with the patient and sometimes even more frequently with their family members. On the other hand, physicians are involved in the entire process of communication in treatment and prognosis of the patient and also communication involves patient's family, too. Specifically, among healthcare workers, both for physicians and nurses, communication is an important tool for maintaining a therapeutic relationship over time and requires ongoing training of health care professionals. In the last thirty years there has been a revolution in the relationship between health worker and patient, which has led to the transition from a paternalistic conception, of psychological subjection of the patient, to a recognition of the status of citizen as a person, holder of rights and duties, which he intends to exercise even when he is in the condition of disease and suffering. Adequate communication allows the patient to contribute to the choice of proposed therapies, increases compliance and adherence to therapeutic prescriptions, facilitates the sharing of opinions and the possibility for the patient to ask for clarification on any doubts. Undoubtedly, today the scales, due to the increased value placed on patient autonomy and patient requests, have shifted towards the suggestion/obligation to tell the truth and inform the patient about his or her state of health, even if this means giving bad news. The essential elements of good communication are welcoming, understanding the patient's pain, allowing the patient and family members to express themselves, empathy and listening. In the oncology setting, several studies in the literature highlight the importance of communication technique when delivering bad news to patients and their families (4,5). Several studies show how, in the absence of specific training or the support of a psychologist, protocols specifically created to facilitate the health care provider in the role of delivering bad news can be used. Among the contributions related to 'how' to deliver bad news, the indications formulated by Buckman and Baile in the communication of bad news in oncology are the most internationally accepted. According to their protocol, termed SPIKES (6), six steps should be considered when giving bad news: initiate the interview, explore what the patient knows, understand how much the patient wants to know, share the information with the patient, take into account the patient's emotions, and plan and accompany the patient (6). The goal of this model is to enable the physician to adequately prepare for communication, convey the news appropriately, provide support to the patient, and gain the patient's cooperation. In the oncology setting, communication has the following goals: to create a relationship based on trust; to bring out the patient's concerns, needs, and emotions; to lead the patient and family as close to clinical reality as possible; to give complex information, "bad news," and discuss difficult topics, such as transition to palliative care and death (7). A review of studies shows that nurses working in oncology settings can communicate bad news and maintain communication with their patients and families effectively. However, nurses may not be aware that they lack adequate knowledge and skills when communicating bad news (8). Instead, feeling prepared, educated, and well rehearsed can increase confidence and self-efficacy when delivering bad news. Many nurses and physicians perceive a lack of adequate training in communicating bad news in their practice settings (9-13). One of the main functions of communication is to convey some information as "something neutral, quantitatively measurable, relative to a subject who perceives it and ascribes meaning to it" (14,15). Information must always be anchored to highly scientific parameters, eschewing the dissemination of messages promising therapeutic results not endorsed by the scientific community. In health care, the complexity of communication increases in relation to the fears and anxieties of the patient who lives the experience of the disease and often to the lack of training/preparation of health workers towards communication, as a therapeutic tool, which integrates skills of verbal, nonverbal and para-verbal communication, where para-verbal means the tone, volume and rhythm of the voice. Nonverbal and para-verbal communication allow one to strengthen bonds, experience sensory and depth, and understand the character of the person with whom one is relating (16). While for a long time, more importance was given to verbal communication, considering it "noble" than nonverbal communication, several researches have shown how the former alone is not sufficient to express the complex domain of interaction, which instead is complemented and integrated by nonverbal language (17,18). The voice, through tone, rhythm, frequency, pauses, allow to convey emotions (19), while posture, facial expressions, gestures and eye contact, through a kinesic system, assume a predominant role in giving greater importance to what is enunciated. Communicating bad news is also a stressful moment for the healthcare professional, especially when they are inexperienced in how to communicate or the prognosis is particularly grave. The stress of breaking the bad news is reduced when it is certain that the patient wants full disclosure of his or her health condition (20). One study found that involving patients in the care process contributed to greater job satisfaction and engagement of health care providers, especially nurses, as well as greater patient satisfaction, with positive outcomes on clinical outcomes, psychological impact, and patient safety (21). The most successful interventions, therefore, are those that recognize patients not as passive recipients of care but as active decision makers who can use their own social support resources (21,22). Since few studies have been conducted on this topic, we wanted to analyze any differences in bad news communication attitudes associated to the compe-

tence level acquired by each health professional recruited, such as physicians and nurses. Additionally, we also investigated any differences in attitudes in bad news communications existed between nurses and physicians interviewed, too.

Materials and Methods

Study approach

An observational, cross sectional, multicenter study was conducted from March to August 2021. An *ad-hoc* questionnaire was created and then, on-line administered, to all Italian physicians and nurses, through social-professionals' pages in Facebook and Instagram, in order to reach the different realities on the national territory.

The questionnaire was addressed to all physicians and nurses employed in Italy, both in public or private health sector.

The questionnaire

The survey instrument was created ad hoc and was structured into two main sections. In the first part of the questionnaire, socio-demographic data were collected in order to better understand if sampling characteristics could influence attitudes in bad news communication, specifically:

- gender, as female or male;
- marital status, as: single or unmarried, married, separate, widower;
- age, divided into groups of age, as: 20-30 years, 31-40 years, 41-50 years, 51-60 years and 61-70 years;
- years of work experience, as until 5 years and over 6 years;
- job role, as interviewer was a physician or a registered nurse;
- religious beliefs, as: Christian, Islamic, Hindu, Buddhist, Atheist, and other not mentioned before;
- work setting, as: critical area, medical area, surgical area, maternal and child area, prevention and safety territorial area or Covid-19 area;
- training achieved in patient communication; as: conferences or courses, master's degree or higher education course, field experience or non-specific training course.

The second part of the questionnaire contained a total of 22 ad hoc items created to investigate both the attitude and perceptions of the professionals during the communication of bad news, gathering information about the modes of communication and places. The guiding principle in the ideation of this second part in the questionnaire is inspired by the importance given to effective communication for greater patient satisfaction as well as a positive influence on the patient's condition of health does not always go hand in hand with an adequate capacity and preparation of the healthcare personnel who often complain of the lack of adequate training, as well as the absence of adequate places to address issues that can be particularly upsetting for the patient (23). Additionally, for each item, a 4-point Likert scale was associated with each item, where 1 indicates, "Never," 2: "Sometimes," 3: "Often," and 4: "Always." Table I included all the 22 items proposed.

Data Analysis

Data were collected in an Excel spreadsheet and analyzed using the SPSS version 20 program, IBM.

All data, being categorical variables, were presented in numbers and percentages according to job role declared, such as: physician or nurse and then, any differences were

Table I. ***Items proposed to explore attitudes and perceptions in bad news communication among physicians and nurses***

Item no.1:	Do you choose a quiet, private place in advance to communicate bad news?
Item no.2:	Do you make sure there is no interruption?
Item no.3:	Do you schedule time to spend on communication?
Item no.4:	First, do you present to the patient?
Item no.5:	Do you call patients by name?
Item no.6:	Are you looking at the patient's face or eyes while you talk or listen?
Item no.7:	Before starting the conversation, look for a relative or loved one of the patient who already knows the news you are about to communicate?
Item no.8:	Before starting the conversation, try to figure out if the patient knows or has already guessed something?
Item no.9:	Before communicating the bad news to the patient, try to understand in which personal, social, and work life areas it may affect?
Item no.10:	At the point when the patient says they do not want to be informed, do you give them time to think about it?
Item no.11:	Do you tend to facilitate dialogue with the patient or let them vent?
Item no.12:	Does it take into account the patient's opinion?
Item no.13:	Do you use appropriate language to allow the patient to process the news they just received?
Item no.14:	Communicate information in a sequential and organized manner, not giving more information until you are sure that the information given, has been well assimilated?
Item no.15:	Do you ask the patient what their feelings are?
Item no.16:	When the patient's response is anxiety, fear, sadness, aggression, do you maintain an active listening attitude?
Item no.17:	Do you show nonverbal support and understanding?
Item no.18:	When communicating bad news, do you stand assertively, expressing your thoughts with confidence?
Item no.19:	If the patient disagrees, does he/she wait for your proposal to find the solution to the problem?
Item no.20:	Do you observe the emotions that emerge in the patient following the bad news?
Item no.21:	Do you ensure that at the end of the conversation the patient has no doubts or questions?
Item no.22:	Do you establish a plan of care with the patient, if necessary, in order to address the new situation?

assessed thanks to the *Chi square* test. By taking into account the level of personal preparation with respect to the issue of communication with the patient and the job role, linear regressions were performed to each item of the questionnaire proposed in order. All p<.05 values were considered significant. Finally, for any significant association frequencies and percentages were assessed in order to better understand the trend of the significant associations evaluated.

Ethical Considerations

Before answering the questionnaire, each participant had to give his or her free consent to the processing of personal data according to the Declaration of Helsinki and in full compliance with privacy regulations. Complete anonymity of the data collected with the mere purpose of investigating the objective of the study was ensured.

All participants who did not provide consent were not included among the subjects participating in the study. In addition, to ensure that the questionnaires were anonymous and to allow for participant identification, a sequential identification (ID) number was assigned to each registered participant. Each questionnaire, therefore, had an ID number that corresponded to the database ID.

Results

Demographic characteristics of the sample

A total of 317 health care providers, including 265 nurses and 52 physicians participated in the survey (Table I). Most of physicians were male (12.90%), while most of nurses were female (63.40%). Both among physicians and nurses, most of them were married (p=.061), work in several areas without any particular trend (p=.229) and also improved their competences in bad news communication in several training contexts, without any particular relevant frequency (p=.356). Additionally, most of the participants were Christians (p<.001), were employed over 6 years in their roles (p=.002) and also aged between 41-50 years and 51-60 years (p=.006).

Table I. *Sampling characteristics between physicians and nurses (n=317)*

Characteristics	Physicians n=52 (16.40%)	Nurses n=265 (83.60%)	p-value
Gender			
Female	11(3.50%)	201(63.40%)	>.001*
Male	41(12.90%)	64(20.20%)	
Marital status			
Single	12(3.80)	107(33.80)	.061
Married	36(11.40)	131(41.30)	
Separate	4(1.30)	24(7.60)	
Widower	0(0)	3(0.90)	
Age			
20-30 years	1(0.30)	56(17.70)	.006*
31-40 years	13(4.10)	59(18.60)	
41-50 years	14(4.40)	75(23.70)	
51-60 years	22(6.90)	64(20.20)	
61-70 years	2(0.60)	11(3.50)	
Work experience			
Until 5 years	3(0.90)	64(20.20)	.002*
Over 6 years	49(15.50)	201(63.40)	
Religion beliefs			
Christian	37(11.70)	234(73.80)	>.001*
Islamic	3(0.90)	1(0.30)	
Hindu	3(0.90)	0(0)	
Buddhist	2(0.60)	1(0.30)	
Atheist	7(2.20)	20(6.30)	
Others not mentioned	0(0)	9(2.80)	
Work area			
Critical area	14(4.40)	62(19.60)	.229
Medical area	20(6.30)	82(25.90)	
Surgical area	16(5.00)	73(23.00)	
Maternal and child area	2(0.60)	13(4.10)	
Prevention and safety	0(0)	7(2.20)	
Territorial area	0(0)	20(6.30)	
Covid-19 area	0(0)	8(2.50)	
Training in patient communication			
Conferences/courses	9(2.80)	64(20.20)	.356
Master's degree	6(1.90)	21(6.60)	
Experience	15(4.70)	54(17.00)	
Non-specific training course	22(6.90)	126(39.70)	

*p<.05 is statistical significant

Attitudes and modes of communicating bad news

By considering attitudes and perceptions in bad news communication associated to the competence levels acquired and their job roles, as physician or nurse (Table II), the job role seemed to be implicated in the matters dealt with the item no.5 (p=.004), item no.6 (p<.001), item no.12 (p<.001), item no.16 (p<.001), item no.17 (p=.007), item no.20 (p=.038). By considering the competence acquired in the bad news communication, significant associations were assessed for the item no.1 (p=.012), item no.3 (p=.002), item no.9 (p=.038), item no.10 (p=.012), item no.11 (p=.042), item no.14 (p=.016), item no.15 (p=.001), item no.19 (.001), item no.20 (p=.003), item no.21 (p=.018) and item no.22 (p=.001).

By considering significant associations between job role and attitudes and perceptions in bad news communication, Table III showed all frequencies and percentages obtained: both physicians and nurses interviewed always called their patients with their names (item no.5), declared to look at the patient's face or eyes when they talk or listen to them (item no.6), took into account their patients' opinions (item no.12), always or often they maintained an active listening attitude (item no.16), they also payed attention to their non-verbal support (item no.17) and also observed their patients after the communication in bad news (item no.20). Therefore, the job role did not seem to be a discriminant role in the attitude abovementioned, as both physicians and nurses answered with the same trend.

By considering significant associations between attitudes and perceptions in bad news communication according to training courses performed, frequencies and percentages assessed for each significant associations (Table IV), showed that most of the interviewers without any training courses on this topic always:

- chose quiet and private place to communicate bad news (item no.1);
- scheduled also their time to spend on this typology of communication (item no.3);
- before communicating a bad news, they tried to understand in which life areas it could be affected (item no.9);
- when the patient said they did not want to be informed, they give them time to think about it (item no.10);
- tended to facilitate dialogue with the patient (item no.11);
- communicated information in a sequential and organized manner (item no.14);

Table II. ***Attitudes and perceptions in bad news communication associated to job role competence acquired variables***

Items	Job role Physician/Nurse			Competence acquired		
	β	t	p-value	β	t	p-value
Item no.1	-.025	-.443	.658	-.141	-2.521	.012*
Item no.2	.028	.503	.615	-.106	-1.894	.059
Item no.3	.010	.174	1862	-.171	-3.706	.002*
Item no.4	.099	1.765	.078	-.072	-1.277	.203
Item no.5	.163	2.931	.004*	.037	.659	.510
Item no.6	.202	3.660	>.001*	-.066	-1.188	.236
Item no.7	-.004	-.066	.947	-.074	-1.309	-.191
Item no.8	.064	1.137	.257	-.080	-1.433	.153
Item no.9	.098	1.755	.080	-.116	-2.086	.038*
Item no.10	.106	1.913	.057	-.140	-2.522	.012*
Item no.11	.081	1.452	.147	-.114	-2.038	.042*
Item no.12	.195	3.549	>.001*	-.093	-1.696	.091
Item no.13	.025	.449	.654	-.044	-.774	.439
Item no.14	.036	.643	.521	-.135	-2.418	.016*
Item no.15	.082	1.479	.140	-.182	-3.290	.001*
Item no.16	.191	3.451	.001*	-.071	-1.293	.197
Item no.17	.151	2.719	.007*	-.077	-1.381	.168
Item no.18	.050	.883	.378	-.070	-1.237	.217
Item no.19	.049	.883	.378	-.184	-3.317	.001*
Item no.20	.115	2.086	.038*	-.166	-3.011	.003*
Item no.21	-.085	-1.524	.129	-.132	-2.375	.018*
Item no.22	-.096	-1.750	.081	-.193	-3.508	.001*

*p<.05 is statistical significant

Table III. *Attitudes and perceptions in bad news communication between physicians and nurses*

Items /Job role	Never n(%)	Sometimes n(%)	Often n(%)	Always n(%)
Item no.5				
Physician	8(2.50)	14(4.40)	17(5.40)	13(4.40)
Nurse	18(5.70)	50(15.80)	86(27.10)	11(35.00)
Item no.6				
Physician	2(0.60)	8(2.50)	10(3.20)	68(21.50)
Nurse	1(0.30)	3(0.90)	32(10.10)	193(60.90)
Item no.12				
Physician	1(0.30)	6(1.90)	20(6.30)	25(7.90)
Nurse	3(0.90)	5(1.60)	72(22.70)	185(58.40)
Item no.16				
Physician	3(0.90)	8(2.50)	19(6.009)	22(6.90)
Nurse	1(0.30)	11(3.50)	108(34.10)	145(45.70)
Item no.17				
Physician	1(0.30)	11(3.50)	19(6.00)	21(6.60)
Nurse	2(0.60)	14(4.40)	117(36.90)	132(41.60)
Item no.20				
Physician	0(0)	7(2.20)	23(7.30)	22(6.90)
Nurse	5(1.60)	10(3.20)	97(30.60)	153(48.30)

*p<.05 is statistical significant

- asked the patient what their feelings were (item no.15);
- observed the emotions that emerge in the patient following the bad news (item no.20);
- ensured that at the end of the conversation the patient had no doubts or questions (item no.21).

On the other hand, interviewers answered that most often they:

- waited to find the solution to the problem, if the patients disagreed the first solution (item no.19);
- established a plan of care with the patient in order to address the new situation (item no.22).

Discussion

The purpose of our study is to analyze any differences in bad news communication attitudes associated to the competence level acquired by each health professional recruited, such as physicians and nurses. Additionally, we also investigated any differences in attitudes in bad news communications existed between nurses and physicians interviewed, too.

The results of the study indicate a greater participation of nurse practitioners compared to physicians, a fact that may indicate how necessary it is to overcome the belief that the communication of bad news is of exclusive medical relevance (24). Among study participants, approximately half, or 46.7% (n=148), stated that they had no specific training, while the remainder claimed to have attended master's or advanced training courses in 8.5% (n=27) of cases. 23% (n=73) attended conferences, while 21.8% (n=69) acquired their skills through work experience. Our data were in agreement to the current literature, which highlighted the constant need for physicians and nurses to communicate bad news to patients, despite very few emphases on formal training in effective communication was given in the training curriculum. There is also evidence-based literature on how to have difficult conversations in the work place or how to give bad news to a patient. In this regard, several literature addressed to an effective approach in communication, with proposes helpful, practical strategies to effective communication in the workplace during patient care, by requiring adequate preparation, true self-knowledge and responsibility, consideration and good listening skills from both patient and healthcare professional, in order to maintain a positive, hopeful message during the communication, by individualizing information to the specific situation and person, appropriate control of emotions, and efficient plans for support and follow-up after the conversation, too (25). However, from our data emerged a considering significant associations between job role and attitudes and perceptions in bad news communication, as: both physicians and nurses interviewed always called their patients with their names (item no.5), declared to look at the patient's face or eyes when they talk or listen to them (item no.6), took into account their patients' opinions (item no.12), always or often they maintained an active listening attitude (item no.16), they also payed attention to their non-verbal support (item no.17) and also observed their patients after the communication in bad news (item no.20). Therefore, the job role did not seem to be a discriminant role in the attitude abovementioned, as both physicians and nurses answered with the same trend, as literature convey to a unique statement: poor communication may lead to life-threatening difficulties, as better communication practice depend on proper communication training to health care professionals (26-28). In this regard, literature also highlights the need for healthcare professionals to look beyond the traditional focus on communication skills in education and include topics such as working with families, managing ethical dilemmas, conflict resolution, team working

Table IV. *Attitudes and perceptions in bad news communication according to training performed*

Items / Training in patient communication	Never n(%)	Sometimes n(%)	Often n(%)	Always n(%)
Item no.1				
Conferences/courses	2(0.60)	11(3.50)	24(7.60)	36(11.40)
Master's degree	1(0.30)	4(1.30)	14(4.40)	8(2.50)
Experience	5(1.60)	10(3.20)	22(6.90)	32(10.10)
Non-specific training course	13(4.10)	29(9.10)	58(18.30)	48(15.10)
Item no.3				
Conferences/courses	9(2.80)	13(4.10)	34(10.70)	17(5.40)
Master's degree	3(0.90)	10(3.20)	11(3.50)	3(0.90)
Experience	9(2.80)	17(5.40)	32(10.10)	11(3.50)
Non-specific training course	36(11.40)	41(12.90)	51(16.10)	51(16.10)
Item no.9				
Conferences/courses	1(0.30)	12(3.80)	33(10.40)	27(8.50)
Master's degree	3(0.90)	6(1.90)	14(4.40)	4(1.30)
Experience	5(1.60)	11(3.50)	24(7.60)	29(9.10)
Non-specific training course	14(4.40)	35(11.00)	58(18.30)	41(12.90)
Item no.10				
Conferences/courses	1(0.30)	6(1.90)	14(4.40)	52(16.40)
Master's degree	0(0)	5(1.60)	10(3.20)	12(3.80)
Experience	1(0.30)	8(2.50)	18(5.70)	42(13.20)
Non-specific training course	9(2.80)	15(4.70)	50(15.80)	74(23.30)
Item no.11				
Conferences/courses	1(0.30)	4(1.30)	32(10.10)	36(11.40)
Master's degree	0(0)	1(0.30)	18(5.70)	8(2.50)
Experience	0(0)	8(2.50)	31(9.80)	30(9.50)
Non-specific training course	4(1.30)	13(4.10)	80(25.20)	51(16.10)
Item no.14				
Conferences/courses	1(0.30)	3(0.90)	30(9.50)	39(12.30)
Master's degree	0(0)	3(0.90)	13(4.10)	11(3.50)
Experience	2(0.60)	2(0.60)	26(8.20)	39(12.30)
Non-specific training course	7(2.20)	10(3.20)	77(24.30)	54(17.00)
Item no.15				
Conferences/courses	2(0.60)	7(2.20)	24(7.60)	40(12.60)
Master's degree	0(0)	7(2.20)	13(4.10)	7(2.20)
Experience	2(0.60)	8(2.50)	26(8.20)	33(10.40)
Non-specific training course	10(3.20)	30(9.50)	63(19.90)	45(14.20)
Item no.19				
Conferences/courses	1(0.30)	12(3.80)	34(10.70)	26(8.209
Master's degree	0(0)	2(0.60)	15(4.70)	10(3.20)
Experience	3(0.90)	8(2.50)	34(10.70)	24(7.60)
Non-specific training course	4(1.30)	36(11.40)	85(26.80)	23(7.30)
Item no.20				
Conferences/courses	0(0)	2(0.60)	21(6.60)	50(15.80)
Master's degree	0(0)	3(0.90)	10(3.20)	14(4.40)
Experience	0(0)	3(0.90)	26(8.20)	40(12.60)
Non-specific training course	5(1.60)	9(12.80)	63(19.90)	71(22.60)
Item no.21				
Conferences/courses	0(0)	0(0)	24(7.60)	49(15.50)
Master's degree	0(0)	2(0.60)	10(3.20)	15(4.70)
Experience	1(0.30)	3(0.90)	18(5.70)	47(14.80)
Non-specific training course	2(0.60)	9(2.80)	58(18.30)	79(24.90)
Item no.22				
Conferences/courses	1(0.30)	8(2.50)	23(7.30)	41(12.90)
Master's degree	1(0.30)	5(1.60)	15(4.70)	6(1.90)
Experience	1(0.30)	9(2.80)	26(8.20)	33(10.40)
Non-specific training course	9(2.80)	31(9.80)	63(19.90)	45(14.20)

*p<.05 is statistical significant

and supporting coping and adaptation to support bad news such as interpreters and private spaces and the provision of opportunities for structured learning and reflection (29).

From this study, it was found that with regard to the attitudes that are assumed in the communication of bad news, professionals often choose a quiet and confidential

place, try not to be interrupted while interacting with the patient, planning the communication time. Professionals, before starting the conversation, try to understand if the patient has already guessed something, this in addition to facilitating the introduction of the topic is necessary for the professional to disprove erroneous information that the patient has been able to acquire from unreliable sources (30,31), 56.8% of respondents stated that they allow time for the patient to reflect. In the following points it emerges how professionals in most cases, take into account the opinion of the patient, observe his emotions, involve him in decisions and in the care plan, and more than half of the respondents (59.9%) said they always make sure that the patient has understood the information he received, thus recognizing his uniqueness, as already expressed in the study of (32), which emphasizes the importance of patient-centered care. A further aspect is related to the need to use an appropriate language and the respect of the processing time of the news, to allow the acquisition of information that due to the strong emotional impact are often forgotten (33), such as the reduced attention span manifested by patients sometimes in 50.2% (n=159) of cases, and often in 25.6% (n=81). In this regard literature is in agreement to our findings, as providing information is the most important communication goal, and greater experience with communicating bad news is connected with higher ratings of this goal, by also reducing the health professional's discomfort (34).

LIMITATIONS

The results should be interpreted taking into account some limitations. The use of online platforms to collect responses could have led to possible bias selection; the sample is not representative of all the Italian physicians and nurses employed both in the public and private healthcare sector. Additionally, the questionnaire administered was created *ad hoc,* without any validation study before.

Conclusions and implications for clinical practice

Although today care is based on scientific evidence and guidelines, on teamwork between the various professionals who take care of the patient in his uniqueness, the communication of bad news in particular, needs to be recognized in the same way as those procedures that characterize the care itself, and for which we try to ensure the highest possible quality. Aspect still too often underestimated and entrusted to character peculiarities or experience gained during his professional career, recognizes in the protocol S.P.I.K.E.S. a tool that can guide the professional in the conduct of the conversation with the patient, can promote a relationship of cooperation and trust between the parties, but whose knowledge is still not widespread. It emerges from the study the need to train health professionals, especially nurses. The presence of a professional psychologist in all work settings could be useful to allow professionals to better address this moment that for the patient represents a multidimensional process of deep and intimate personal change. In addition, future studies could analyze both the knowledge, attitudes and perceptions of other health professionals with respect to communication.

References

1) Bongiorno, A., & Malizia, S. Comunicare la diagnosi grave: il medico, il paziente e la sua famiglia. Carocci Faber, 2002.
2) Fallowfield I, Jenkins V. Communicating sad, bad, and difficult news in medicine. Lancet 2004; 363: 312.
3) Prati G, Pietrantoni L. La comunicazione di bad news nel lavoro in polizia. https://www.researchgate.net/publication/306567517 Chapter · January 2012.
4) Bousquet G, Orri M, Winterman S, Brugière C, Verneuil C, Revah-Levy A. Breaking Bad News in Oncology: A Metasynthesis. Journal of Clinical Oncology, August 2015. https://doi.org/10.1200/jco.2014.59.6759.
5) Rao A, Ekstrand ML, Heylen E, Raju G, Shet AS. Breaking Bad News: Patient Preferences and the Role of Family Members when Delivering a Cancer Diagnosis. Asian Pacific journal of cancer prevention: APJCP 2016; 17(4): 1779-84.
6) Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES—a six-step protocol for delivering bad news: application to the patient with cancer. The oncologist 2000; 5(4): 302-311.
7) Rossi F. La comunicazione in oncologia: un iceberg sommerso. Piesse 2017; 3: 4-1.
8) Adebayo PB, Abayomi O, Johnson PO, Oloyede T, Oyelekan AA. Breaking bad news in clinical setting—Health professionals' experience and perceived competence in Southwestern Nigeria: A cross sectional study. Annals of African Medicine 2013; 12: 205-211. https://doi.org/10.4103/1596-3519.122687
9) Breaking Bad News in Oncology: A Metasynthesis Guilhem Bousquet, Massimiliano Orri, Sabine Winterman, Charlotte Brugière, Laurence Verneuil, and Anne Revah-Lev. Journal of clinical oncology 2015; 33: 22.
10) Al-Mohaimeed AA, Sharaf FK. Breaking Bad News Issues: A Survey Among Physicians Oman Med Journal. 2013; 28(1): 20-25.
11) Schildmann J, Cushing A, Doyal L, Vollmann J. Breaking bad news: experiences, views and difficulties of pre-registration house officers. Palliative Medicine 2005; 19: 93-98.
12) Lusso VC. Dinamiche e ostacoli della comunicazione interpersonale. In: Dinamiche e ostacoli della comunicazione interpersonale. Trento: Erickson, 2018.
13) Messana C. Comunicazione interpersonale, in Franco LEVER - Pier Cesare Rivoltella - Adriano Zanacchi (edd.), La comunicazione. Dizionario di scienze e tecniche, www.lacomunicazione.it (10/08/2021).
14) Paccagnella L. Sociologia della comunicazione, Bologna, Il Mulino, 2004.
15) Agnolli L. Fondamenti di psicologia della comunicazione, Bologna, Il Mulino, 2012.
16) Chain M. https://www.theepochtimes.com/the-dying-art-of-conversation-has-technology-killed-our-ability-to-talk-face-to-face_2865431.html. 2019
17) Mohammadi K. The Eyes Have It: Communication and Face Masks. The Guardian (2020). Available online at: https://www.theguardian.com/lifeandstyle/2020/may/30/face-mask-eye-contact-commuication-coronavirus
18) Borg J. Body Language: 7 easy lessons to master the silent language. Ft Press, Upper SAddle River, 2009.
19) Ciceri MR, Anolli LM. La voce delle emozioni. Verso una semiosi della comunicazione …non-verbale delle emozioni. Franco Angeli, Milano 2000: IV edizione 512
20) Tuckett AG. Truth-telling in clinical practice and the arguments for and against: a review of the literature. Nurs Ethics. 2004; 11(5): 500-13. https://doi.org/10.1191/0969733004ne728oa.
21) Ding B, Liu W, Tsai SB, Gu D, Bian F, Shao X. Effect of Patient Participation on Nurse and Patient Outcomes in Inpatient Healthcare. Int J Environ Res Public Health. 2019; 16(8): 1344. https://doi.org/10.3390/ijerph16081344.

22) Cutica I, Mc Vie G, Pravettoni G. Personalised medicine: the cognitive side of patients. European Journal of Internal Medicine 2014; 25(8): 685-688.
23) Fleischer S, Berg A, Zimmermann M. et al. Interazione e comunicazione infermiere-paziente: una revisione sistematica della letteratura. J Salute pubblica 2009; 17: 339-353. https://doi.org/10.1007/s10389-008-0238-1.
24) Orsi L, Biasi F, Sempreboni A, Busatta L, Mazzon D. Communicating bad news in intensive or palliative care: From unawareness to fulcrum of the therapeutic relationship. BioLaw Journal 2017. https://doi.org/10.15168/blj.v9i1.219.
25) Mezu-Ndubuisi O. Communicating Bad News in the Health Care Organization. In: Patole, S. (eds) Management and Leadership – A Guide for Clinical Professionals. Springer, Cham. 2015. https://doi.org/10.1007/978-3-319-11526-9_19
26) Tiwary A, Rimal A, Paudyal B, Sigdel KR, Basnyat B. Poor communication by health care professionals may lead to life-threatening complications: examples from two case reports. Wellcome Open Res. 2019; 4: 7. https://doi.org/10.12688/wellcomeopenres.15042.1.
27) Bartlett G, Blais R, Tamblyn R, Clermont RJ, MacGibbon B. Impact of patient communication problems on the risk of preventable adverse events in acute care settings. CMAJ. 2008 Jun 3; 178(12): 1555-62. https://doi.org/10.1503/cmaj.070690.
28) Vermeir P, Vandijck D, Degroote S, Peleman R, Verhaeghe R, Mortier E, Hallaert G, Van Daele S, Buylaert W, Vogelaers D. Communication in healthcare: a narrative review of the literature and practical recommendations. Int J Clin Pract. 2015 Nov; 69(11): 1257-67. https://doi.org/10.1111/ijcp.12686.
29) Warnock C, Buchanan J, Tod AM. The difficulties experienced by nurses and healthcare staff involved in the process of breaking bad news. Journal of Advanced Nursing. 2017. https://doi.org/10.1111/jan.13252
30) Hesse BW, Nelson DE, Kreps GL, Croyle RT, Arora NK, Rimer BK, Viswanath K. Trust and sources of health information: the impact of the Internet and its implications for health care providers: findings from the first Health Information National Trends Survey. Arch Intern Med. 2005; 165(22): 2618-24. https://doi.org/10.1001/archinte.165.22.2618.
31) Hesse BW, Shneiderman B. eHealth research from the user's perspective. Am J Prev Med. 2007; 32(5 Suppl): S97-103. https://doi.org/10.1016/j.amepre.2007.01.019.
32) Levinson W, Lesser CS, Epstein RM. Developing physician communication skills for patient-centered care. Health Aff (Millwood). 2010; 29(7): 1310-8. https://doi.org/10.1377/hlthaff.2009.0450.
33) Mazzocco K, Masiero M, Carriero MC, Pravettoni G. The role of emotions in cancer patients' decision-making. Ecancermedicalscience. 2019; 13: 914. https://doi.org/10.3332/ecancer.2019.914.
34) Sweeny K, Shepperd JA, Han PKJ. The goals of communicating bad news in health care: do physicians and patients agree? Health Expectations 2013; 16: 230-238. https://doi.org/10.1111/j.1369-7625.2011.00709.x

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