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Review Article

The patients' preferences in breaking bad news: A scoping review

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ABSTRACT

Background & Aim: Patients' preferences in breaking bad news to the patients may vary from one culture and society to another. This study aimed to determine patients' preferences for breaking bad news.
Methods & Materials: This scoping review study was conducted on the articles published in databases, including Scopus, Web of Science, Proquest, Embase, and Medline (PubMed) up to the end of December 2023. After removing the duplicate results. The titles and abstracts of the articles were reviewed to observe the probable connections with the review question, and the unrelated items were omitted. The original articles, which were published in English entered into the study. The articles that have reported patients' preferences in emergency settings or parents' preferences for breaking bad news, were excluded from the study. The textual data were extracted from the remaining articles and then analyzed using conventional content analysis.
Results: Fifty-nine studies included in this review about the patients' preferences were classified into four categories: "the right to know what is happening to them", "receiving emotional support", "participating in decision-making", and "observing the requirements of giving the bad news to the patients". Nonetheless, there were variations in patients' preferences among different backgrounds.
Conclusion: Given the influence of the patient's background in breaking bad news, the existing solutions in Western communities may not be practical or completely useful for Eastern. The results of this study can be used to observe patients' preferences in breaking bad news from different backgrounds.

Introduction

Breaking bad news is a complex and challenging task that involves communicating information that adversely and seriously affects an individual's view of his or her future. Breaking bad news can have various forms and contexts, such as disclosing a diagnosis of a life-threatening or chronic illness, informing about a poor prognosis, revealing a treatment failure, or announcing a death (1).

Depending on how the news is delivered and received, breaking bad news can cause strong emotional reactions, such as shock, anger, sadness, fear, or guilt, as well as unpleasant behaviors or feelings, such as denial, avoidance, blame, or hopelessness, in the listener. Moreover, breaking bad news can have lasting effects on the person's cognitive, behavioral, or emotional functioning, such as impairing memory, decision-making, coping, or quality of life (2, 3).

Breaking bad news is a difficult and sensitive task that can have profound effects on the person who receives it. Therefore, it is essential to adopt a systematic and empathetic approach that takes into account the individual's preferences, needs, and expectations. This can help to reduce the negative impact of the bad news and enhance the communication and trust between the person and the health care provider (4).

The manner of breaking bad news can have profound psychological and emotional consequences for the patients and their families. Inappropriate communication of bad

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news can induce anxiety, confusion, hatred, and anger among the recipients. Conversely, appropriate communication of bad news can alleviate unrealistic expectations, denial, false disappointment, confusion, and anxiety among the recipients (3).

Moreover, the communication strategies of breaking bad news can significantly influence the patients' and their families' perceptions of the illness, their future interactions with the healthcare providers, and their satisfaction with the care (4). Therefore, breaking bad news requires a systematic and empathetic approach that considers the individual's preferences, needs, and expectations (5).

As the healthcare environment becomes increasingly culturally diverse, it is important to explore how different cultures influence patients' preferences in receiving bad news. Culture is a broad and dynamic term that encompasses various aspects of a person's identity, values, beliefs, attitudes, and behaviors. Culture can influence how people perceive, understand, and cope with health and illness, as well as how they communicate and interact with healthcare providers. Therefore, culture can also affect how patients prefer to receive bad news, such as who should be present, what information should be disclosed, how much detail should be given, what tone and style should be used, etc. (6).

Different studies show that the duration, content, and management of breaking bad news in Eastern cultures differ from those suggested in Western societies' clinical guidelines (7). For example, concealment of the truth about diseases is very common in many Eastern and the Middle East due to the central role of the families and the priority of the principle of avoiding harm over individual discretion (8,9). In the Middle East, a legitimate conspiracy of silence regarding a cancer diagnosis often takes place, intending to maintain the patient's hope. A cancer diagnosis is usually revealed by the physician only to one or more family members. However, informed consent policies and truth-telling attitudes have become applicable in some countries of the Middle East region, and truth-telling about a cancer diagnosis has become the mainstay of contemporary medical practice in some of these countries (9).

Still, it is much more important to consider the patient's preferences in breaking bad news, regardless of cultural background. It is reported that sometimes patients' preferences may not overlap with their culture. In other words, in many cases, these preferences might also be in conflict (10, 11).

Lack of transparency and clarification of different patients' preferences in giving bad news may lead to ineffective communication between the patient and the physician, which can lead to irreparable consequences for the patients. Conducting a scoping review on patients' preferences from different cultures in breaking bad news, is necessary to identify the commonalities and variations among different cultural groups, as well as the gaps and challenges in the current knowledge and practice of breaking bad news. This will help inform and improve the communication skills and strategies of healthcare providers who face breaking bad news to patients from diverse cultural backgrounds. Therefore, the present review study was conducted to determine patients' preferences for breaking bad news.

Methods

A scoping review was performed to examine the patients' preferences for breaking bad news. Scoping reviews explore evidence to examine key trends and research gaps on a specific topic (12). We followed Arksey and O'Malley's scoping review framework utilizing the five main stages: identifying a research question, identifying relevant literature, selecting literature, charting data, and reporting findings (13). The PRISMA Extension for Scoping Reviews - PRISMAScR was followed in reporting the findings of our scoping review (12). The PCC (Population, Concept, Context) framework is a tool that can help you to operationalize your scoping review question and select the relevant studies. Please see the PCC component in Table 1.

Table 1. Population, Concept, Context in Breaking Bad News

PCC Component	Description
Population	Patients who receive bad news
Concept	Culture and patients' preferences in breaking bad news
Context	Different types and stages of diseases, different settings and situations, different countries and regions

This scoping review was conducted to answer the following research question, what is known from the existing literature about the patients' preferences from different cultures in breaking bad news? The articles published until the end of December 2023 were reviewed in the following databases: Scopus, Web of Science, Proquest, Embase, and PubMed. The searches were done using some English keywords based on the Medical Subject of the Heading (MESH), including breaking bad news, patients' preferences, Culture, cross-cultural, and ethics. The reference lists of the selected studies were also reviewed. First, the duplicate results from the databases were deleted. Then the titles and abstracts of the articles were reviewed to observe the probable relations with the question of this scoping review, and the unrelated papers were omitted after full texts of the remaining articles were reviewed and evaluated in terms of the inclusion and exclusion criteria. Inclusion criteria were the original articles, patients were at least 18 years old. The letter or proceeding, the articles that reported the patients' preferences in emergency conditions, were excluded. That is because the patients' preferences in emergencies can differ from their preferences in non-emergency situations, as emergencies are characterized by high acuity, urgency, uncertainty, and stress. Moreover, the emergency department is a unique and complex setting that poses specific challenges and barriers to breaking bad news, such as lack of privacy, time constraints, interruptions, and multiple providers. Besides, since the researchers intended to analyze the patients' preferences, the parents' preferences about their sick child were not in line with the subject of the present study.

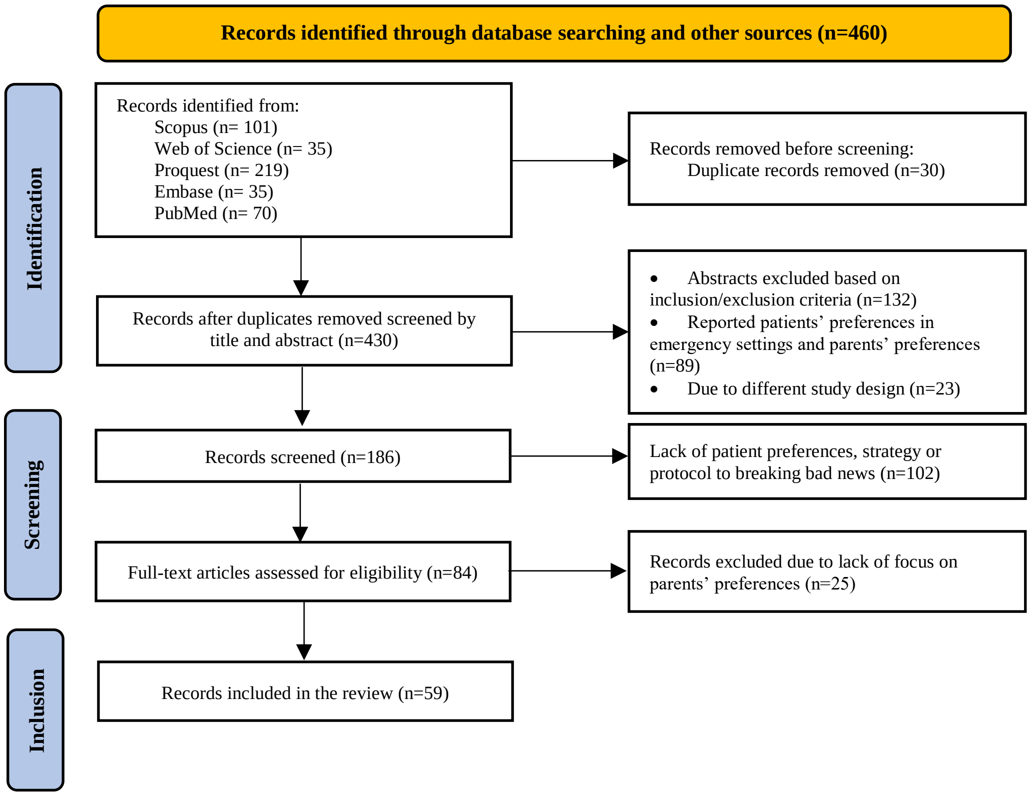

Figure 1. PRISMA Flow diagram

Two reviewers (AB and RN) independently conducted a literature search and reviewed the titles and abstracts yielded by this comprehensive search and subsequently selected articles based on the predetermined inclusion and inclusion criteria. Disagreements between reviewers were resolved by consensus or by the decision of a third independent reviewer. Charting in scoping review is a technique for synthesizing and interpreting qualitative data by sifting, charting, and sorting material according to key issues and themes (13). It is utilized to identify commonalities and themes, which focuses on our scoping research question. The data charting form included the names of the authors, the name of the journal in which the article was published, the year of publication, the type of the article, and the content related to patients' preferences in breaking bad news.

We utilized qualitative content analysis to synthesize the extracted data. Conventional content analysis is more suitable to use when there is little literature that supports and gives information about a specific topic. The initial step is reading and re-reading the textual data to understand the whole. Then, the texts are divided into smaller parts that are called meaning units. The next step is coding and categorizing. Depending on the purpose of the research, the themes that contain the highest level of abstraction may be created for presenting results (14). In this stage, a descriptive summary of the study characteristics was provided. Moreover, results were reported in a narrative form focusing on the identified themes that emerged from the literature associated with the patient's preferences in breaking bad news. This study was approved by the Ethics Committee of Tehran University of Medical Sciences (no. IR.TUMS.VCR.REC.1398.175).

Results

Fifty-nine studies from 27 different countries were reviewed (Figure 1). Most of the studies were conducted in Asian countries (n=30). In contrast, 15 studies were conducted in European countries, eight were conducted in America, three were conducted in Australia, and only three were conducted in Africa. Most of the studies have been conducted on cancer patients (50 studies). Most of the studies were cross-sectional (n=43), only eleven were qualitative, three were prospective cohort studies, and two were mixed methods. Table 3. Provided detailed information on included studies in the present scoping review.

Although Patients' preferences for breaking bad news differed among countries, the commonality of patients' preferences was summarized in the four categories (Table 2).

The right to know what is happening to them

The patients' preference to be informed was highlighted in most of the articles which were reviewed. Regardless of their backgrounds, awareness of the disease was the only common category among all the patients. Despite these preferences, patients also vary in terms of their awareness of their disease, and each patient expressed different interpretations of awareness. For example, patients in some countries such as Argentina and Brazil were willing to know the diagnosis of their disease; they would also prefer to know all the details of the disease, such as the severity of the disease, the side effects of the treatment, best treatment options, the possibility of the treatment, treatment outcomes, prognosis, and even the results of laboratory tests (15-17). In some studies, the patient's preferences were classified by age, sex, and education. For example, having a university education among American patients is regarded as necessary for the amount of information required from physicians (18, 19). Moreover, educated patients in Iran and Albania are willing to know their life expectancy and diagnosis. The majority of young Australian and Albanian patients would prefer to obtain medical information, which shows the impact of age on breaking bad news (20, 21). Gender also plays a significant role in breaking bad news where Taiwanese female patients tend to be aware of their possible lifetime and detailed information about their disease (22). In addition to Taiwan, the role of gender in giving bad news was also observed among Iranian and Saudi Arabian patients (23, 24).

Table 2. Patients' preferences in breaking bad news

Categories	Codes
The right to know what is happening to them	1. Awareness of • All of the different treatment options • Best treatment options • All possible side-effects of treatments • The daily and week-to-week progress is during treatment • The effect of selective treatment on other patients • Cases in which the treatment used has not been effective • Other aspects of treatment and adverse and poor outcomes • Disease prognosis • Disease-specific medical name • Impact of disease on daily functioning • The causes of the disease • Detailed information about laboratory test results • The chances of a cure • Life expectancy • The diagnosis despite the incurability of the disease • Diagnosis of the disease • Diagnose and prognosis the disease before informing the family • The diagnosis immediately after confirmation of the disease • The desire of younger, women, educated and high-income patients to be aware of the diagnosis • The possibility of disease or disability • Risk of possible death or death in the near future • Experimental therapies • The involvement of all or part of the body with the disease • Whether the disease is inherited or contagious 2.Determine the amount of information provided by the patient 3. Get permission from the patient before giving bad news 4.Get informed first 5. Awareness of the disease even despite the seriousness of the disease and family opposition 6.Family awareness of the diagnosis 7.The family does not hide the truth
Receiving emotional support	1. Receive support resources such as religion and family 2. Request emotional support from your physician 3. Do not leave the patient by the physician 4. Physician to give patient hope 5. Emotional and cognitive support from the physician 6. Really listen to me 7. Support services available 8. The physician is sensitive to the feelings of family members 9. The presence of other caregivers (such as nurses) to provide emotional support to patients and their family members 10. Hear from your physician that he will do his best to cure cancer 11. Sensitivity to the patient's feelings, needs and emotions during the interaction 12. The patient does not receive all the information properly due to the reaction to the bad news 13. Need to refer to nurses to receive the missing parts of the information and confirm the received information 14. Free expression of emotions 15. The presence of health care providers such as nurses and psychologists along with the physician to respond to patients ' needs. 16.Reluctance to touch by a physician
Participating in decision making	1. Decide on the treatment of choice immediately after diagnosis 2. Decision making without the participation of others 3. Participate in decision making with family members 4. Respect the physician 's opinion even if he disagrees with the patient's opinion 5. Respect for patient autonomy 6.Old age equates to more dependence on the physician in decision making 7. Pay attention to the physician 's advice in comparison with the family in choosing treatment 8. Participate in decision making with the physician
Observing the requirements of breaking bad news to the patients	1.Giving bad news face to face, slowly and gradually 2.Adopt a realistic approach that is appropriate to the patient's condition by the physician 3.Awareness of the disease by the family physician 4.Giving bad news directly and honestly 5.Use positive words when giving bad news, was not using medical terms that the patients could not understand 6.Awareness of the disease by the physician 7.Avoid disturbing the atmosphere / giving bad news 8.Provide an opportunity to talk to your physician again with a loved one 9.Be honest about the severity of the disease 10.Being told in private setting, in person, Maintain eye contact 11.Have enough time to ask questions 12.Physician devote enough time for delivering bad news 13.Physician encouraged them to ask questions about the diagnosis 14.Physician awareness of the latest research findings 15.Ensure the skill and competence of the physician 16.Acceptance of responsibility for patient care by the physician until the end of the disease 17.Giving bad news without interruption, simple language and appropriate words to the person, clearly, without intermediaries, without ambiguity and in a way that is easy to understand 18.Get bad news in a private room, not in the hallway or emergency room 19.Make the necessary preparations before giving bad news 20.Tendency to patient-centered communication

Receiving emotional support

It is a common attitude among patients in Eastern countries and many patients in Western countries such as the United States; these patients would also prefer to receive emotional support from their physicians while breaking bad news (25). On the other hand, the patients' culture would determine the physicians' expression of emotional support. For example, given that the family is one of the essential sources of support in Eastern cultures, such as Japanese cultures, the patients prefer to be emotionally supported by the physicians and their families (23, 26). In Western countries such as the United States, emotional support from physicians is sufficient, and the patients do not need any other sources of support (27). The patients believe that emotional support while breaking bad news should 0 the need for comprehensive attention by the physicians to the patient's emotional reactions, developing hope among the patients, and free expression of feelings. After breaking bad news, receiving supportive resources and sensitivity to the patient's feelings, needs, and emotions are also necessary. People in North America and East Asia, such as Japan and Singapore, prefer to receive the physicians' full attention; they also expect the physicians to listen carefully to their patients (26, 28, 29).

Participation in decision-making

Decisions are mainly made without the patients' presence and involvement in Eastern countries because physicians only take action after consulting the patients' family members. However, many patients in Asian countries such as China and Japan prefer to participate in decision-making (10, 30). Moreover, some patients like to make independent decisions (27). Previous studies have also rejected the idea that independent decision-making is only common among patients in Western countries. On the other hand, some patients in several Western countries, such as the United Kingdom, prefer to make decisions in collaboration with their physicians (8, 31). It is noteworthy that independent or collaborative decision-making is based on the patient's awareness of the disease. Hence, the patients need to be aware of the diagnosis, prognosis, and treatment options to participate in the decision-making process.

Observing the requirements of breaking bad news to the patients

Due to cultural differences, the ideal conditions for breaking bad news may differ for the patients. The culture of the community can determine whether the patients tend to receive the bad news by themselves or along with a family member. This is one of the most obvious differences between Eastern and Western countries. The presence of the family while receiving the bad news can be regarded as the most prominent feature of the Eastern culture among the patients in Nigeria, India, Portugal, and Iran (23, 32- 35). Due to the family's importance in Eastern countries, the family's presence while receiving bad news is necessary from the patients' perspective because the family is considered the supporter, counselor, and guide for the patients. In addition to the influence of culture on the presence of the family in breaking bad news, gender also plays a vital role in this regard. For instance, unlike Taiwanese men, Taiwanese women prefer to be with their family members while receiving bad news (22). Another difference between Eastern and Western countries in breaking bad news is implementing positive words while giving bad news. Positive words are only common in Eastern countries, and patients consider it one of the most influential factors in breaking bad news. (17, 36, 37). Nevertheless, there are many similarities between Eastern and Western countries regarding breaking bad news requirements. For example, giving bad news clearly and directly to the patient is observed in Western countries such as the United States and Canada (18, 27) and in Asian countries such as Japan (10). Regardless of the cultural differences, a physician should be available to respond to the patient's questions, and the patients should have enough time to ask questions. In other words, they should highlight the disease and medical services.

Patients in different countries prefer to receive bad news from their physicians (16, 20); in the meantime, they also prefer to visit physicians with the necessary capabilities and skills in this field (8, 28) Furthermore, the patients prefer to visit the same physician they were referred to for the first time (10). Finally, skilled physicians should be aware of the latest research findings in their specialized fields so that they can help or guide the patients appropriately and provide the necessary information in response to the patients' probable questions.

Table 3. Summary of included studies in the present scoping review

Author	Year	Country	Design	Population/Sample size
Krieger T et al	2023	Germany	Qualitative study	23 cancer patients with 13 different tumor entities participated. Being enrolled 12 months post-diagnosis.
Ayalew EA et al	2023	Ethiopia	Qualitative study	In-depth interviews were employed to collect data from eight patients who were diagnosed with cancer and cancer with HIV/AIDS during the time of data collection
Al-Johani WM et al	2022	Arabia Saudi	Mixed methods	An in-depth interview and cross-sectional quantitative analysis. Theme 1; patients' requirements for BBN and theme 2; patients' reaction at the time of diagnosis with their categories. For the quantitative part, a total of 222 patients responded to the survey
Zardoui A et al	2022	Iran	Cross-sectional	170 cancer patients' companions and 170 non-cancer patients' companions
Martina D et al	2022	Indonesia	Qualitative study	semi-structured interviews among 16 patients with cancer and 15 family caregivers in a national cancer center in Jakarta and a tertiary academic general hospital in Yogyakarta
Benelhaj NE et al	2022	United Kingdom	Qualitative study	Eleven participants were semi-structured interviews. The most common primary tumor sites were gastrointestinal cancer (n=5), lung cancer (n=3), and genitourinary cancer (n=3). Ten had advanced-stage cancer.
Abraha Woldemariam et al	2021	Ethiopia	Cross-sectional	patients with a confirmed cancer diagnosis, their family caregivers, and representatives from the general public with 150 subjects per cohort
Basheikh M et al	2021	Arabia Saudi	Cross-sectional	500 adult patients and companions (age 18 years and above) who visited one of the participating clinics during the study period were included. Patients having cancer or terminal illnesses or their companions
Fan Z et al	2019	China	Cross-sectional	216 cancer patients, 242 families, and 176 clinical staff members
Alzahrani AS et al	2018	Arabia Saudi	Cross-sectional	304 cancer patients and 277 family members were involved in the study. All participants in the study were Muslims.
Chen SY et al	2018	Taiwan	Qualitative study	20 patients with cancer (10 men and 10 women).
Goebel S et al	2018	Germany	Cross-sectional	42 patients with an intracranial tumor shortly after neurosurgical tumor removal
Lee GL et al	2018	Singapore	Cross-sectional	18 cancer patients who had not been told of their diagnosis, were attending an initial oncology consultation for diagnosis and treatment plans and were age 21 years or older and their accompanying persons were recruited from the outpatient clinics.
Liu Y et al	2018	China	Prospective	A consecutive series of 124 patients who had been diagnosed with malignancy by pathology and 124 their family member
Sobczak K et al	2018	Poland	Cross-sectional	314 tumors, nervous system diseases, disorders of pancreatic internal secretion, blood disorders, and cardiovascular diseases, musculoskeletal diseases, other cancer patients at least 18 years
Yennurajalingam S et al	2018	Argentina	Cross-sectional	1490 participants survey of advanced cancer patients referred to palliative care
Hoseynrezaee H et al	2017	Iran	Cross-sectional	214 cancer patients at least 18 years old who were referred to the selected hospitals for therapeutic or palliative care
Abazari P et al	2016	Iran	Qualitative study	35 participants (15cancer patients age 18 years or older, 6 family members were had a close relationship with the patient, 9 physicians, and 5 nurses were had at least 1 year's experience in the treatment and care of cancer patients)
Aminiahidashti H et al	2016	Iran	Cross-sectional	130 patients above the age of 18 who were admitted with a definite diagnosis of a malignant or chronic disease.
Rao A et al	2016	India	Qualitative study	127cancer patients and family members in the medical oncology clinic of a tertiary referral hospital in Bangalore, India
Wei S et al	2016	China	Cross-sectional	Thirty-three pairs of patients confirmed diagnosis of locally advanced or metastatic gastrointestinal cancer and their caregivers
Ardestani SM et al	2015	Iran	Cross-sectional	126 cancer patients admitted to the oncology departments of 3 referral medical centers
Farhat F et al	2015	Lebanon	Cross-sectional	343 physicians, nurses, cancer patients, families, and friends from clinics in two major hospitals in Lebanon.
Karim SM et al	2015	Arabia Saudi	Cross-sectional	100 adult patients attending the oncology out-patient clinic with cancer diagnosed at least 3 months prior to recruitment, aware of their diagnosis
Arbabi M et al	2014	Iran	Cross-sectional	200 cancer patients at a cancer institute in Tehran
Jordan P et al	2014	Argentina	Prospective	Adult patients with, have a diagnosis of a primary malignancy (n=55) or severe COPD (n=54)
Seifart C et al	2014	Germany	Cross-sectional	350 cancer patients in an inpatient and outpatient setting of the University Hospital Marburg (UKGM) and the rehabilitation center Klinik Sonnenblick, Marburg, Germany
Adeleye AO et al	2013	Nigeria	Cross-sectional	109Native Nigerian-African adult patients (and their relations) who had a life-course-altering neurosurgical diagnosis
Beqiri A et al	2012	Albania	Cross-sectional	One hundred and fifty consecutive cancer patients, 150 respective relatives, and an age-sex–residence–matched sample of 150 individuals in Tirana
Cheah WL et al	2012	Malaysia	Cross-sectional	200 adult cancer patients while awaiting their turn to be seen in the clinic. Patients aged 18 years and above who had been informed regarding the diagnosis of cancer at least 1 month prior to recruitment.
Eng TC et al	2012	Malaysia	Cross-sectional	30 bone cancer patients
Brown VA et al	2011	United Kingdom	Cross-sectional	244 oncology outpatients (new, follow-up, chemotherapy, and radiotherapy appointments)
Pardon K et al	2011	Belgium	Cross-sectional	128 consecutive patients with an initial diagnosis of NSCLC, stage IIIb or IV.
Al-Amri AM	2010	Arabia Saudi	Cross-sectional	332 Saudi cancer patients who received oncological care

Author	Year	Country	Design	Population/Sample size
Ishaque S et al	2010	Pakistan	Cross-sectional	236 females (59%) and 164 males aged between 18 to 60 at The Aga Khan University Hospital (AKUH), Karachi
Jawaid M et al	2010	Pakistan	Cross-sectional	147 cancer patients from different hospitals
Al Amri AM	2009	Arabia Saudi	Cross-sectional	114 Saudi Arabian cancer
Mauri E et al	2009	Italy	Cross-sectional	210 patients were either actively receiving chemotherapy or they were visiting the clinic for follow-up monitoring. patients must have been diagnosed with cancer and informed of their condition at least 1 month earlier; diagnoses included new cancer, recurrence, or disease progression.
Deschepper R et al	2008	Belgium	Qualitative study	In-depth interviews with 17 terminal cancer patients had to be over 18 years old, have advanced illness with a life expectancy of about 3 months (estimated by the GP)
Doumit MA et al	2008	Lebanon	Qualitative study	In-depth semi-structured interviews were carried out with a purposeful sample of six women and four men cancer patients aged from 21 to 71
Fujimori M et al	2007	Japan	Cross-sectional	529 patients were cancer outpatients who were attending follow-up medical appointments, which treat mainly breast, digestive, head and neck, and lung cancer. patients who were deemed by their physician and their medical chart to have received bad news regarding cancer three or more months earlier, including news of the diagnosis, recurrence, disease progression, or the absence of active anticancer treatment.
Fujimori M et al	2007	Japan	Cross-sectional	529 patients the delivery of bad news (i.e. cancer diagnosis, recurrence, treatment failure, or discontinuation of active anticancer treatment) at least 3 months prior to the start of the study.
Chiu LQ et al	2006	Singapore	Cross-sectional	200 cancer patients diagnosed and informed of their condition at least 1 month earlier.
Gongal R et al	2006	Nepal	Prospective	A survey of 96 patients with advanced cancer admitted to 'Hospice Nepal' over the one-year study period. A survey of the 256 general population in Kathmandu was carried out
Fujimori M et al	2005	Japan	Qualitative study	49 participants, including 42 cancer patients and 7 oncologists
Gonçalves F et al	2005	Portugal	Cross-sectional	47 cancer patients were referred to the outpatient clinic of a palliative care unit.
Hagerty RG et al	2005	Australia	Cross-sectional	126 patients were the consecutive metastatic cancer patients of 30 oncologists, who were diagnosed within 6 weeks to 6 months before recruitment, over 18 years of age, and without known mental illness.
Keating DT et al	2005	Ireland	Cross-sectional	207 patients admitted to a respiratory and geriatric unit were asked whether and how they would wish to be told of cancer or Alzheimer's disease.
Davison BJ et al	2004	Canada	Cross-sectional	Eighty-seven men (mean age 62.4 years) referred to an ultrasound/radiology department for their first transrectal ultrasonography (TRUS)-guided biopsy
Pinto RN et al	2004	Brazil	Cross-sectional	Two-hundred and ninety-eight patients were examined at an oncological cancer center in São Paulo
Tang ST et al	2004	Taiwan	Cross-sectional	Cancer patients have been confirmed by histological diagnoses and were 18 years of age or older. Preferences of information from healthcare professionals and attitudes toward disclosing information to family and even respecting family's opinions not to disclose the life-threatening diagnosis and prognosis to patients have also been explored from the cancer patient's point of views
Jenkins V et al	2001	United Kingdom	Cross-sectional	2331A heterogeneous sample of patients attending out-patient clinics large teaching hospital cancer centers and smaller district general hospitals.
Parker PA et al	2001	United States of America	Cross-sectional	351 patients with a variety of cancers
Schofield PE et al	2001	Australia	Cross-sectional	131 newly diagnosed melanoma patients were surveyed approximately 4 months after initial diagnosis
Benson J et al	1996	United Kingdom	Qualitative study	30 patients in whom cancer, excluding basal and squamous cell skin carcinomas, was diagnosed 1-7 years earlier.
Butow PN et al	1996	Australia	Cross-sectional	144 Patients with breast cancer or melanoma
Fallowfield L et al	1995	United Kingdom	Cross-sectional	101 patients with heterogeneous diagnoses mean age of the group was 43 (range 21-75)
Sardell AN et al	1993	United States of America	Mixed methods	10 physicians and 10 patients with cancer. Fifty-seven statements were rated on two bipolar rating scales describing hopefulness and favorability by an additional 56 patients with recent onset of cancer. To determine if overall emotional adjustment to the illness affected these ratings, scores on the Mental Adjustment Scale were also obtained.
Cassileth BR et al	1980	United States of America	Cross-sectional	256 cancer patients had a median age of 55.5 years and had been diagnosed for an average of 10 months.

Discussion

The current scoping review was conducted to identify patients' preferences regarding breaking bad news. The main categories that emerged were "The right to know what is happening to them", "Receiving emotional support", "Participating in decision making", and "Observing the requirements of breaking bad news". Bearing in mind that the patients have the right to receive enough information about the disease and its prognosis, the present study's findings provide useful information about the importance of paying attention to this issue, especially from the patient's preferences.

The "right to know what is happening to them" was the first category extracted from data synthesis. Providing the necessary information about the disease is now regarded as a patient's right in many societies (6). Many patients around the world, including Africa, North, and Latin America, Asia, Europe, as well as Australia, prefer to be informed about their diagnosis (15, 23, 27, 32, 33, 38); there are very few patients who are reluctant to be informed of the diagnosis (23). In this regard, the communication pattern is changing from the physician-centered and disease-oriented models to the new approaches to patient-centered and human-centered models. In a patient-centered health system, the main focus is on the patients' needs and concerns rather than the physicians' decisions and priorities (39). The main objective of the patient-centered model is to trigger the participation of the patients and their families in the provision of medical services (40). Robb and Seddon have defined the patient-centered model as including the concepts of patients' awareness and participation, respect for the patients' preferences, patients' involvement in the treatment process, respectful treatment of the patients, development of treatment processes according to the patients' needs, ease of access to health information, and continuity of treatment (41).

Different models have been developed regarding breaking bad news, such as SPIKES (42), ABCDE (43), PEWTER (44), BREAK (45), and TALK (46). However, these models are generally designed based on the findings of the studies that have examined the physicians' perspectives on breaking bad news, and it seems that there is a kind of modern patriarchal view toward the development of these instructions where the patients cannot play any roles. On the other hand, cultural differences in the Eastern and Western countries of the world have challenged breaking bad news about diseases, especially when patients have serious and life-threatening complications. The challenges would be more severe when the therapists and the patients do not have a common culture (6). Given that culture can play an essential role in the individuals' interpretation of health care, cultural diversity directly affects healthcare services.

"Receiving emotional support" was the second category that was extracted from the data. The majority of the patients expect to receive enough information with empathy and compassion while facing the treatment staff, especially the physicians (1). While breaking bad news and sharing unpleasant conditions with the patients and their families, skilled and thoughtful physicians should wisely implement the following important issues and measures in order to develop a supportive program to help the patients alleviate the pain and control the progression of their disease: expressing empathy and showing actual emotional feelings and reactions (not false feelings) to the patients to accompany them in grief and anxiety (47). Emotional support is regarded as one of the most important symbols in Eastern countries, whose most important realization is observed in the presence of the family and its role in breaking bad news to the patients (10, 23). The patients would also seek emotional support in Western countries, where the emotional support is undoubtedly different from the wide range of support in Eastern countries, which is far beyond the presence of the family while breaking bad news (48). People in Eastern countries often prefer to receive bad news directly from physicians along with their family members (23). The patients' family members are considered the best protectors when receiving bad news; the families can also play a supportive role in different ways (49). Despite the limited role of families' emotional support in Western countries compared to Eastern countries, it should not be disregarded while breaking bad news because patients in Western countries such as the United States prefer to receive emotional support from physicians (25). In addition to the family, religion is also regarded as an important part of the culture in each society which can also provide emotional support. In some countries such as Iran and Lebanon, where religion plays an important role in the culture of society, the patients prefer to take into account their religious circumstances while receiving bad news; the patients also prefer that religious counselors visit them after receiving bad news (11, 50).

"Participation in decision-making" was the third category. Adults have the right to decide how to take care of their health (51). Accordingly, Patients in most cultures would tend to participate in decision-making. Therefore, once receiving the necessary information about their health and probable treatment measures, the patients need to make their own decisions. Clinical handover of patients has improved communication with them, created an opportunity to participate in the care plan, and found answers to their questions. The traditional decision-making process by the health care professionals was based on the idea that they are the only people who know what is best for the patients; however, the patients should be regarded as the focus of attention in the hospital and also, instead of the service providers, the patients should determine which aspects of the service are most beneficial (39). Recently, the physicians and the patients have collaborated in making decisions, and they should consider the patients' values and choices. In other words, apart from the medical benefits, the patients' benefits should also be taken into account. Therefore, physicians should not assume that a long life would be the best option for all patients; some patients may prefer a shorter but painless life instead. Unlike many Western countries, the dominant traditional culture in Eastern countries highlights the role of the family in making decisions because the family is regarded as the basis for decision-making (6). For example, mothers and grandmothers play significant roles in African families and should be involved in health-related decisions (32).

"Observing the requirements of breaking bad news to the patients" was the fourth category extracted from the data. Breaking bad news to the patients and their families about their health status, diagnoses, and prognoses can significantly affect their lives. The approach to breaking bad news can have a facilitating or debilitating effect on the patients' self-esteem; it can also play a positive or negative role in their treatment process. On the other hand, patients have the right to be informed of their health status according to medical ethics principles. Disclosure of the bad news properly can lead to accepting the treatment, greater satisfaction, and lower anxiety levels among the patients (50). As a result, the main question is not whether we should break the bad news or not; rather, the focus should be on how and under what circumstances we should give the bad news. To decide how much information should be provided to the patients, the physicians should always consider the patients' preferences; besides, the patients should always be encouraged to receive information according to their needs so that they can participate in the decision-making process accordingly (52).

Moreover, breaking bad news in an appropriate environmental, emotional, social, and even scientific condition and establishing a rational and ethical relationship with the patients and their relatives can reduce the severity of the bad news (53). The requirements of breaking bad news to the patient can provide the conditions and opportunities to give the bad news that aim to eliminate or lower the negative effects of breaking bad news to the patients. This can only be achieved if the patients set such requirements and express their preferences on receiving the bad news. The physicians are responsible for acquiring the necessary information about the patients' preferences before breaking bad news. In addition, given that the patients' culture plays a particular role in giving bad news, the physicians should not implement the same method for all the patients (10, 37) Therefore, the physicians who do not have the required skills to give the bad news have no right to break it, even though the patients trust them. The physicians are responsible for properly giving the bad news to the patients and their close relatives. They need to develop good communication skills to break the bad news to the patients appropriately (1). The researchers should investigate the physicians' acquisition of necessary skills through analysis of the patients' preferences and required training courses in this field, which can resolve one of the most critical concerns regarding the approaches toward breaking bad news to the patients. Evaluating the patients' complaints shows that they are not related to the physicians' scientific skills but their communication skills. On average, the physicians interrupt their patients within the first twenty-three seconds; they do not also answer the patients' questions in more than 50% of the outpatient visits. The physicians only spend less than a single minute explaining the prescriptions to the patients; accordingly, the patients are afraid to ask questions because they fear getting involved with the physicians (39). The physicians responsible for breaking bad news to the patients should be with the patients until the end of the treatment procedure. They should refrain from delegating the responsibilities to other physicians (10). Since the patients and their relatives are only satisfied with the physicians if they can break bad news, the physicians must acquire and appropriately implement the required communication skills (1). Interpersonal distance is regarded as one of the important communication skills that should be taken into account while breaking bad news, which may vary from one culture to another. Therefore, the invasion of the patients' personal and private territory can upset them. It can also cause the patients to refrain from treatment adherence or avoid returning for follow-up interventions. Direct and steady gaze and tactile approaches may not be acceptable to the majority of patients in Eastern countries such as Japan (10). Accordingly, the therapists must acquire skills in breaking bad news and expertise (1).

Most of these studies have been conducted in Asian countries, distinctively different from North American and Western nations about individuality and personal rights, in Asian cultures, the ethical principles of nonmaleficence and beneficence may predominate over the principle of respect for autonomy. Asian cultures emphasize providing security, serenity, tranquility, and hope. Also, the relative power and importance attributed to the social world are emphasized more in the Asian culture (54). According to our knowledge, this study is the first synthesis to evaluate patients' preferences in breaking bad news through a scoping review. This study suffers from limitations including when reading articles related to a culture in a specific geographical area over a period of several years, there is a change in attitudes about giving bad news to patients, making it challenging to analyze patients' preferences for the bad news.

This scoping review suggests that healthcare providers who break the bad news to patients from diverse cultural backgrounds should develop appropriate guidelines that are tailored to the patients' preferences and respect their autonomy, dignity, and values, based on the best available evidence and the stakeholders' input, and that can adapt to different cultures and contexts. They should also provide education and support to healthcare providers and patients on breaking bad news, including communication skills and strategies, emotional and practical support, and information and resources on coping with bad news. Moreover, they should engage with patients and families in breaking bad news and decision-making, including building rapport and trust, listening and responding, acknowledging and validating, exploring and respecting their choices and preferences, and seeking and incorporating their feedback. These interventions could help to reduce the negative impact of the bad news and enhance the communication and trust between the person and the health care provider, as well as improve the patients' outcomes, such as their knowledge, understanding, coping, quality of life, satisfaction, and trust.

Conclusion

Given the influence of the patients' background in breaking bad news, the existing solutions in Western communities may not be practical or completely useful for Eastern societies. Developing appropriate guidelines tailored to the patient's preferences in breaking bad news can help facilitate compliance. Contrary when the patients' preferences are ignored, people may avoid further visits to the treatment team or refer too late, which can endanger their health and, on a larger scale, threaten society's health. Most of the studies included in this review were observational studies and there was no interventional study, it seems necessary to develop educational and supportive interventions based on the main findings of the current study and evaluate their impact by conducting rigorous clinical trials. It is suggested that future studies will assess the contextual factors to identify and explain the influences of culture on breaking bad news practices. As well, how to give bad news to patients under 18, and giving bad news at emergency times are other things that can be explored in future studies.

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Conflict of interest

The authors declare that there is no conflict of interest.

References

1. Shakeriniya I. Telling bad news: the necessity of its training. Iranian Journal of Medical Ethics and History of Medicine. 2010 Mar 10; 3 (1):29-38.
2. Buckman R. Breaking bad news: why is it still so difficult? British Medical Journal (Clinical research ed.). 1984 May 5; 288(6430): 1597-99.
3. Warnock C, Tod A, Foster J, Soreny C. Breaking bad news in inpatient clinical settings: role of the nurse. Journal of Advanced Nursing. 2010 Jul; 66(7): 1543-55.
4. Gilbey P. Qualitative analysis of parents' experience with receiving the news of the detection of their child's hearing loss. International Journal of Pediatric Otorhinolaryngology. 2010 Mar 1; 74(3): 265-70.
5. Mori M, Lin CP, Cheng SY, Suh SY, Takenouchi S, Ng R, et al. Communication in cancer care in Asia: A narrative review. JCO Global Oncology. 2023; 9: e2200266.
6. Zahedi F, Larijani B. Truth telling across cultures: Islamic perspectives. Iranian Journal of Medical Ethics and History of Medicine. 2010 Dec 10; 3(5) :1-11.
7. Gold M. Is honesty always the best policy? Ethical aspects of truth telling. Internal Medicine Journal. 2004 Sep; 34(9-10): 578-80.
8. Giger JN, Davidhizar R. Transcultural nursing assessment: a method for advancing nursing practice. International Nursing Review. 1990 Jan 1;37(1):199-202.
9. Khalil RB. Attitudes, beliefs, and perceptions regarding truth disclosure of cancer-related information in the Middle East: A review. Palliative & Supportive Care 2013 Feb; 11(1): 69-78.
10. Fujimori M, Parker PA, Akechi T, Sakano Y, Baile WF, Uchitomi Y. Japanese cancer patients' communication style preferences when receiving bad news. Psycho-Oncology: Journal of the Psychological, Social and Behavioral Dimensions of Cancer. 2007 Jul; 16(7): 617-25.
11. Abazari P, Taleghani F, Hematti S, Ehsani M. Exploring perceptions and preferences of patients, families, physicians, and nurses regarding cancer disclosure: A descriptive qualitative study. Supportive Care in Cancer. 2016 Nov; 24(11):4651-9.
12. Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and explanation. Annals of Internal Medicine. 2018 Oct 2; 169(7): 467-73.
13. Arksey H and O'Malley L. Scoping studies: Towards a methodological framework. International Journal of Social Research Methodology. 2005 Feb 1; 8(1): 19-32.
14. Mayring P. Qualitative content analysis: A step-by-step guide. SAGE Publications Ltd. Nov 3, 2021.
15. Quadrelli S, Jordan P, Heres M, Belli LF, Ruhl N, Colt H. Examining patients' preferences for participation in clinical decision-making: The experience in a Latin American chronic obstructive pulmonary disease and cancer outpatient population. Internal Medicine Journal. 2014; 44(3): 281-87.
16. Pinto RN, Chaves AC, Lourenço MT, de Jesus Mari J. Information needs of recently diagnosed cancer patients in Brazil. The International Journal of Psychiatry in Medicine. 2004 Dec; 34(4):319-29.
17. Doumit MA, Abu-Saad HH. Lebanese cancer patients: Communication and truth-telling preferences. Contemp Nurse 2008; 28(1-2): 74-82.
18. Parker PA, Baile WF, de Moor C, Lenzi R, Kudelka AP, Cohen L. Breaking bad news about cancer: patients' preferences for communication. Journal of Clinical Oncology. 2001 Apr 1; 19(7): 2049-56.
19. Cassileth BR, Zupkis RV, Sutton-Smith K, March V. Information and participation preferences among cancer patients. Annals of Internal Medicine. 1980 Jun; 92(6): 832-6.
20. Beqiri A, Toci E, Sallaku A, Qirjako G, Burazeri G. Breaking bad news in a Southeast European population: A survey among cancer patients in Albania. Journal of Palliative Medicine. 2012 Oct 1; 15(10):1100-5.
21. Hagerty RG, Butow PN, Ellis PM, Lobb EA, Pendlebury SC, Leighl N, et al. Communicating with realism and hope: incurable cancer patients' views on the disclosure of prognosis. Journal of Clinical Oncology. 2005 Feb 20; 23(6): 1278-88.

22. Chen SY, Wang HM, Tang WR. The differences in preference for truth-telling of patients with cancer of different genders. Cancer Nursing. 2018 Jul 1; 41(4): 320-6.

23. Arbabi M, Rozdar A, Taher M, Shirzad M, Arjmand M, Ansari S, et al. Patients' preference to hear cancer diagnosis. Iranian Journal of Psychiatry. 2014 Mar; 9(1): 8-13.

24. Al-Amri AM. Saudi cancer patients' attitudes towards disclosure of cancer information. Middle East Journal of Cancer. 2010; 1(4): 175-180.

25. Sardell AN, Trierweiler SJ. Disclosing the cancer diagnosis. Procedures that influence patient hopefulness. Cancer. 1993 Dec 1; 72(11): 3355-65.

26. Fan Z, Chen L, Meng L, Jiang H, Zhao Q, Zhang L, et al. Preference of cancer patients and family members regarding delivery of bad news and differences in clinical practice among medical staff. Supportive Care in Cancer. 2019 Feb; 27(2): 583-9.

27. Davison BJ, Parker PA and Goldenberg SL. Patients' preferences for communicating a prostate cancer diagnosis and participating in medical decision-making. BJU International. 2004 Jan; 93(1): 47-51.

28. Chiu LQ, Lee WS, Gao F, Parker PA, Ng GY, Toh CK. Cancer patients' preferences for communication of unfavourable news: An Asian perspective. Supportive Care in Cancer. 2006 Aug; 14(8): 818-24.

29. Lee GL, Teo I, Kanesvaran R. The complexities of doctor–patient–family communication in an Asian oncology setting: concordance and discordance among patient preferences, family preferences, and perceived and actual communication. Health Communication. 2018 Feb 1; 33(2): 95-101.

30. Wei S, Chen F, Chen H, Guo Y, Hui D, Yennurajalingam S, et al. Patients' and family members' decision-making and information disclosure preferences in a single-center survey in China: A pilot study. American Journal of Hospice and Palliative Medicine®. 2016 Sep; 33(8): 733-41.

31. Benson J, Britten N. Respecting the autonomy of cancer patients when talking with their families: qualitative analysis of semistructured interviews with patients. BMJ. 1996 Sep 21; 313(7059): 729-31.

32. Adeleye AO, Fatiregun AA. Is breaking of bad news indeed unacceptable to native A fricans? A cross-sectional survey of patients in a Nigerian neurosurgical service. Acta Neurologica Scandinavica. 2013 Mar; 127(3): 175-80.

33. Rao A, Ekstrand M, Heylen E, Raju G, Shet A. Breaking bad news: Patient preferences and the role of family members when delivering a cancer diagnosis. Asian Pacific Journal of Cancer Prevention. 2016 Apr 1; 17(4): 1779-84.

34. Sobczak K, Leoniuk K, Janaszczyk A. Delivering bad news: patient's perspective and opinions. Patient Preference and Adherence. 2018 Nov 12; 12: 2397-404.

35. Kpanake L, Igier V, Sastre MT. Cultural differences in perceived appropriateness of breaking bad news to patients: A direct comparison of Togo and France. Universitas Psychologica. 2019; 18(2): 1-7.

36. Tse CY, Chong A, Fok SY. Breaking bad news: a Chinese perspective. Palliative Medicine. 2003 Jun; 17(4): 339-43.

37. Fujimori M, Akechi T, Akizuki N, Okamura M, Oba A, Sakano Y, et al. Good communication with patients receiving bad news about cancer in Japan. Psycho-Oncology: Journal of the Psychological, Social and Behavioral Dimensions of Cancer. 2005 Dec; 14(12): 1043-51.

38. Goebel S, Mehdorn HM. Breaking bad news to patients with intracranial tumors: the patients' perspective. World Neurosurgery. 2018 Oct 1; 118:e254-62.

39. Farhadfar AH, Nasiripour AA, Haji Nabi K. A Comprehensive Review of Patient-Centered Care in the Hospitals. Journal of Healtcare Management. 2019; 9(4): 91-8.

40. Delaney LJ. Patient-centred care as an approach to improving health care in Australia. Collegian 2018 Feb 1; 25(1): 119-23.

41. Robb G, Seddon M. Quality improvement in New Zealand healthcare. Part 6: keeping the patient front and centre to improve healthcare quality. The New Zealand Medical Journal (Online). 2006 Sep 22;119(1242): 1-9.

42. 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 Aug 1;5(4):302-11.

43. Rabow MW, McPhee SJ. Beyond breaking bad news: how to help patients who suffer. Western Journal of Medicine.1999; 171(4): 260-3.

44. Nardi TJ, Keefe-Cooperman K. Communicating bad news: a model for emergency mental health helpers. International Journal of Emergency Mental Health. 2006; 8(3): 203-7.

45. Narayanan V, Bista B, Koshy C. 'BREAKS' protocol for breaking bad news. Indian Journal of Palliative Care. 2010; 16(2): 61-5.

46. LoboPrabhu S, Molinari V, Pate J, Lomax J. The after-death call to family members: A clinical

perspective. Aging & Mental Health. 2007 Mar 1;11(2):192-6.

47. Kazemi A, Pursoleimani A, Fakhari A, Madaen K. Truth-telling in medicine: views of Tabriz University of Medical Sciences. Iranian Journal of Medical Ethics and History of Medicine. 2010 Apr 10; 3(2): 54-63.

48. Deschepper R, Bernheim JL, Vander Stichele R, Van den Block L, Michiels E, Van Der Kelen G, et al. Truth-telling at the end of life: a pilot study on the perspective of patients and professional caregivers. Patient Education and Counseling. 2008 Apr 1; 71(1):52-6.

49. Friedrichsen MJ, Strang PM, Carlsson ME. Breaking bad news in the transition from curative to palliative cancer care–patient's view of the doctor giving the information. Supportive Care in Cancer. 2000 Nov; 8(6): 472-8.

50. Farhat F, Othman A, El Baba G, Kattan J. Revealing a cancer diagnosis to patients: attitudes of patients, families, friends, nurses, and physicians in Lebanon—results of a cross-sectional study. Current Oncology. 2015 Aug; 22(4): 264-72.

51. Ibn Ahmadi A, Heydari N. Is there a proper method of truth telling? Iranian Journal of Medical Ethics and History of Medicine. 2010 Apr 10; 3(2): 16-28.

52. Agamohammadi M, Alefbaei A, Babaei F, Biazar N, Gardashkhani S. The attitude of patients and families toward the delivery of bad news in oncology wards. Nursing and Midwifery Journal. 2020 Jan 10;17(12):955-64.

53. Parsa M, Bagheri A, Larijani B. Telling bad news and its various aspects. Iranian Journal of Medical Ethics and History of Medicine.2011; 4(6): 1-14.

54. Tang ST, Lee SY. Cancer diagnosis and prognosis in Taiwan: patient preferences versus experiences. Psycho-Oncology: Journal of the Psychological, Social and Behavioral Dimensions of Cancer. 2004 Jan; 13(1): 1-13.

55. Krieger T, Salm S, Dresen A, Cecon N. Cancer patients' experiences and preferences when receiving bad news: A qualitative study. Journal of Cancer Research and Clinical Oncology. 2023 Jul;149(7):3859-70.

56. Ayalew EA, Mphuthi DD, Matlhaba KL. Patients' preferences for delivering bad news in palliative care in Ethiopia: A qualitative study. BMC Palliative Care. 2023 Nov 3; 22(170):1-9.

57. Al-Johani WM, AlShamlan NA, AlGhamdi MF, AlAbdulkader AM, Aljohani WM, AlGhamdi RF,et al. Breaking Bad News of a Cancer Diagnosis: A Mixed-Methods Study of Patients' Perspectives. Patient Preference and Adherence. 2022 Dec 31;16:3357-69.

58. Zardoui A, Yekaninejad MS, Kazemian A, Parsa M. Assessing the willingness of patients' companions to disclose bad news to cancer patients. Journal of Medical Ethics and History of Medicine. 2022;15. 10.18502 /jmehm.v15i3.9549.

59. Martina D, Kustanti CY, Dewantari R, Sutandyo N, Putranto R, Shatri H, et al. Advance care planning for patients with cancer and family caregivers in Indonesia: A qualitative study. BMC Palliative Care. 2022 Nov 22; 21(1):1-12.

60. Benelhaj NE, Hutchinson A, Maraveyas A, Johnson MJ. Cancer patients' experiences of the diagnosis and treatment of incidental pulmonary embolism (a qualitative study). Plos one. 2022 Oct 25;17(10):e0276754.

61. Abraha Woldemariam A, Andersson R, Munthe C, Linderholm B, Berbyuk Lindström N. Breaking bad news in cancer care: Ethiopian patients want more information than what family and the public want them to have. JCO Global Oncology. 2021 Sep; 7: 1341-8.

62. Basheikh M. Preferences of the Saudi Population in Breaking Bad Medical News: A Regional Study. Cureus. 2021 Nov 13; 13(11): e19525.

63. Alzahrani AS, Alqahtani A, Alhazmi M, Gaafar R, Bajabir D, Alharbi IM, et al. Attitudes of cancer patients and their families toward disclosure of cancer diagnosis in Saudi Arabia: A Middle Eastern population example. Patient Patient Preference and Adherence. 2018 Sep 3; 12: 1659-66.

64. Liu Y, Yang J, Huo D, Fan H, Gao Y. Disclosure of cancer diagnosis in China: the incidence, patients' situation, and different preferences between patients and their family members and related influence factors. Cancer Management and Research. 2018 Jul 23; 10: 2173-81.

65. Yennurajalingam S, Rodrigues LF, Shamieh OM, Tricou C, Filbet M, Naing K, et al. Decisional control preferences among patients with advanced cancer: An international multicenter cross-sectional survey. Palliative Medicine. 2018 Apr; 32(4): 870-80.

66. Hoseynrezaee H, Kordikarimabadi J, Jahani Y. Attitudes of patients with cancer towards truth-telling and self-determination in Kerman, 2016: a cross sectional study. International Journal of Cancer Management. 2017 Sep 30;10(9): e7731.

67. Aminiahidashti H, Mousavi SJ, Darzi MM. Patients' attitude toward breaking bad news; A brief report. Emergency. 2016; 4(1): 34-37.

68. Ardestani SM, Faridhosseini F, Shirkhani F, Karamad A, Farid L, Bordbar MR, et al. Do cancer patients prefer to know the diagnosis? A descriptive study among Iranian patients. Iranian Journal of Psychiatry and Behavioral Sciences. 2015 Dec; 9(4): 1792-1798.

69. Zekri JM, Karim SM, Bassi S, Sadiq B, Abdelghany EM. Breaking bad news: Preferences of cancer patients in Saudi Arabia. Journal of Palliative Care Medicine. 2015; 5(2): 207.

70. Seifart C, Hofmann M, Bär T, Knorrenschild JR, Seifart U, Rief W. Breaking bad news–what patients want and what they get: evaluating the SPIKES protocol in Germany. Annals of Oncology. 2014 Mar 1; 25(3):707-11.

71. Cheah WL, Dollah NB, Chang CT. Perceptions of receiving bad news about cancer among bone cancer patients in sarawak general hospital-a descriptive study. The Malaysian Journal of Medical Sciences: MJMS. 2012 Jul; 19(3): 36-42.

72. Eng TC, Yaakup H, Shah SA, Jaffar A, Omar K. Preferences of Malaysian cancer patients in communication of bad news. Asian Pacific Journal of Cancer Prevention. 2012; 13(6): 2749-52.

73. Brown VA, Parker PA, Furber L, Thomas AL. Patient preferences for the delivery of bad news–the experience of a UK Cancer Centre. European Journal of Cancer Care. 2011 Jan; 20(1): 56-61.

74. Pardon K, Deschepper R, Vander Stichele R, Bernheim J, Mortier F, Schallier D, et al. Are patients' preferences for information and participation in medical decision-making being met? Interview study with lung cancer patients. Palliative Medicine. 2011 Jan; 25(1): 62-70.

75. Ishaque S, Saleem T, Khawaja FB, Qidwai W. Breaking bad news: Exploring patient's perspective and expectations. The Journal of the Pakistan Medical Association. 2010; 60(5):407-11.

76. Jawaid M, Qamar B, Masood Z, Jawaid S. Disclosure of cancer diagnosis: Pakistani patients' perspective. Middle East Journal of Cancer. 2010 Apr 1;1(2):89-94.

77. Al Amri AM. Cancer patients' desire for information: a study in a teaching hospital in Saudi Arabia. EMHJ-Eastern Mediterranean Health Journal. 2009; 15 (1): 19-24.

78. Mauri E, Vegni E, Lozza E, Parker PA, Moja EA. An exploratory study on the Italian patients' preferences regarding how they would like to be told about their cancer. Supportive Care in Cancer. 2009 Dec; 17(12):1523-30.

79. Fujimori M, Akechi T, Morita T, Inagaki M, Akizuki N, Sakano Y, et al. Preferences of cancer patients regarding the disclosure of bad news Psycho-Oncology: Journal of the Psychological, Social and Behavioral Dimensions of Cancer. 2007 Jun; 16(6): 573-81.

80. Gongal R, Vaidya P, Jha R, Rajbhandary O, Watson M. Informing patients about cancer in Nepal: what do people prefer? Palliative Medicine. 2006 Jun; 20(4): 471-6.

81. Gonçalves F, Marques Á, Rocha S, Leitao P, Mesquita T, Moutinho S. Breaking bad news: experiences and preferences of advanced cancer patients at a Portuguese oncology centre. Palliative Medicine. 2005 Oct; 19(7): 526-31.

82. Keating DT, Nayeem K, Gilmartin JJ, T O'Keeffe S. Advance directives for truth disclosure. Chest. 2005 Aug 1; 128(2):1037-9.

83. Schofield PE, Beeney LJ, Thompson JF, Butow PN, Tattersall MH, Dunn SM. Hearing the bad news of a cancer diagnosis: The Australian melanoma patient's perspective. Annals of Oncology. 2001 Mar 1; 12(3): 365-71.

84. Butow PN, Kazemi JN, Beeney LJ, Griffin AM, Dunn SM, Tattersall MH. When the diagnosis is cancer: patient communication experiences and preferences. Cancer: Interdisciplinary International Journal of the American Cancer Society. 1996 Jun 15;77(12):2630-7.

85. Fallowfield L, Ford S, Lewis S. No news is not good news: information preferences of patients with cancer. Psycho-Oncology. 1995 Oct; 4(3): 197-202.