JERN Journal of Education and Research in Nursing

Invited Review

DOI: 10.14744/jern.2025.25902
J Educ Res Nurs. 2025;22(4):1-6

A Phenomenon That Challenges Physicians and Nurses: Breaking Bad News in Oncology

Abstract

Breaking bad news is one of the most common and challenging communication processes healthcare professionals encounter in oncology practice. Conveying negative information to patients regarding diagnosis, prognosis, or treatment is not merely a medical briefing but a complex process involving ethical, legal, and psychosocial dimensions. This review discusses the meaning of breaking bad news, the factors affecting this process in oncology, the ethical and legal dimensions involved, and approaches to delivering such news. It concludes that the process of breaking bad news should be treated as a professional skill, that healthcare workers should be supported in this regard, and that they should be empowered through systematic training programs.

Keywords: Bad news, nurse, oncology, physician

Şenay Gül,[1] Serap Şahinoğlu[2]

[1]Department of Fundamentals of Nursing, Hacettepe University Faculty of Nursing, Ankara, Türkiye

[2]Department of Medical History and Ethics, Ankara University Faculty of Medicine, Ankara, Türkiye

Introduction

Cancer is recognized as one of the most serious health issues worldwide today, profoundly affecting individuals' lives not only biologically but also psychologically, socially, and economically.[1] A cancer diagnosis is a process that fundamentally changes not only the individual's life but also that of their family and close circle, carrying a heavy emotional burden. One of the most challenging tasks for physicians and healthcare teams during this process is breaking bad news to patients and their loved ones. Breaking bad news is not merely a matter of conveying medical information; it is a complex process involving communication, empathy, ethical responsibility, and legal obligations. In oncology practice especially, any negative news regarding diagnosis, treatment, or prognosis can have profound psychological effects on patients and their loved ones. For healthcare professionals, this situation creates significant emotional pressure and ethical dilemmas.

Breaking bad news to a patient is a critical stage that directly affects the individual's adaptation to the disease process, participation in treatment, and quality of life.[2] The literature indicates that breaking bad news appropriately ensures patients' right to access information, helps them assess the disease process more realistically, and increases satisfaction with healthcare services.[3] However, inappropriate delivery of bad news can lead to negative outcomes for patients, such as anxiety, depression, helplessness, and non-compliance with treatment.[4]

From the perspective of healthcare professionals, the process of breaking bad news is not only a patient-centered responsibility but also a professional and ethical obligation. However, many studies emphasize that healthcare workers often do not receive adequate training in this area, experience difficulties with communication skills, and struggle to manage the process effectively.[5] Particularly in oncology practice, the frequent need to convey negative information regarding diagnosis, treatment, and prognosis is a significant factor increasing burnout and emotional distress among healthcare professionals.[2]

This review provides a comprehensive perspective on the subject by addressing the meaning of breaking bad news, the challenges encountered in oncology practice, the factors influencing the process, the ethical and legal implications, and the approaches recommended in the literature.

The Meaning of Bad News

Although breaking bad news is conceptually one of the fundamental problems of medical practice, attention was only drawn to the issue and defined in the 20th century. According to Buckman (1992), the first researcher to explain the concept, bad news is a phenomenon that significantly and negatively affects a person's attitude toward the future.[6] Bad news has also been defined as information that dramatically alters a person's view of the future, causing cognitive, sensory, and behavioral disturbances after receiving it.[7]

Many situations can be considered bad news, such as a cancer diagnosis, chronic disease diagnosis, failure of treatment to result in healing, treatment failure, amputation, conditions causing loss of function, side effects of chemotherapy, a pregnant woman losing her baby, and news of death.[8,9] As can be understood from its definitions, breaking bad news is a process that evokes negativity in the relationship between the physician, nurse,

Cite this article as: Gül Ş, Şahinoğlu S. A Phenomenon That Challenges Physicians and Nurses: Breaking Bad News in Oncology. J Educ Res Nurs. 2025;22(4):1-6.

Corresponding author: Şenay Gül
E-mail: senay.gul@hacettepe.edu.tr

Received: July 14, 2025
Accepted: September 24, 2025
Publication Date: December 01, 2025

DOI: 10.14744/jern.2025.25902
J Educ Res Nurs. 2025;22(4):1-6

patient, and the patient's relatives, regardless of the circumstances or the disease. It is typically news that no one wants to receive or deliver.

The Factors Affecting the Process of Breaking Bad News in Oncology

Cancer is a disease that often evokes death and is perceived as equivalent to death by many people.[10] The diagnosis and treatment of cancer are emotionally, economically, and socially exhausting for patients and their relatives. Because the patient's body is affected by a disease whose treatment will be long and uncertain,[11] it is natural for physicians and nurses to accompany the patient at every stage of this lengthy treatment process. The most challenging issue for healthcare professionals in the diagnosis, treatment, and care of cancer patients is, of course, the process of breaking bad news.[8]

In oncology, patients and their relatives are frequently confronted with bad news. Breaking bad news in medical practice presents various challenges for both the recipient and the person delivering it. The anxiety and fear of not being able to cope with the intense emotions and behaviors that patients and their relatives experience after receiving bad news are among the most fundamental difficulties.[7] On the other hand, the person delivering bad news also confronts their own emotions and death anxiety in this process, which can be counted among the difficulties faced by professionals. In the process of accepting bad news, patients and their relatives interpret the situation according to their traditions, values, and sociocultural structures, and reflect their reactions accordingly.[6] Undoubtedly, physicians and nurses encounter other difficulties in breaking bad news.

The decision to deliver bad news and the manner in which it is communicated are influenced by many factors in oncology. Sociocultural structure plays a significant role in shaping the communication preferences of patients and their relatives regarding cancer. People living in traditional, more protective family structures tend to have different attitudes toward receiving bad news compared to those living in more individualistic societies.[7,8] While there are differences between countries in terms of telling patients the truth about their diagnosis, prognosis, treatment options, and side effects, there is no global consensus on this issue.[12] In North America and Europe, most physicians clearly state the diagnosis to patients. However, in Southern and Eastern Europe, Middle Eastern countries, Japan, and China, patients are more reluctant to receive information about their illnesses than their relatives due to patriarchal views and cultural norms, or the diagnosis is not disclosed to patients because of family intervention.[13] Although this situation has changed over the past 50 years, in our country relatives still have a say in matters concerning the patient. Unfortunately, the practice of telling patients the truth about their cancer diagnosis is not widespread, and this is largely attributed to the influence of cultural norms in Eastern societies.[14] This concealment effort puts relatives, patients, and healthcare professionals in a difficult situation and creates an obstacle to communication with the patient.[10]

There are factors other than culture that affect whether patients and their relatives want to receive bad news. These include past experiences, age, socioeconomic level, personality traits of the patient, the location, stage, and metastasis status of the cancer, the manner in which the bad news is delivered, the role of the physician, and the approach of healthcare professionals.[11] Physicians' insufficient training in breaking bad news, their tendency to overestimate patients' life expectancy, and their personal attitudes towards death directly shape the way they communicate unfavorable information to patients.[10] Sociocultural factors such as physicians' status in society, religious beliefs, philosophy of life, and attitudes toward death may also influence the way they deliver bad news.[15] Healthcare professionals, especially those who work with terminally ill patients at risk of dying, are faced with the reality that they are also mortal. This realization can deeply shake their beliefs, ideologies, and assumptions about the world, and as a result, negatively affect their communication with patients.[16]

In addition to the approaches of physicians and nurses in breaking bad news, the meaning that patients attribute to the disease is also essential. Some patient characteristics may influence their response to bad news: being busy, not making the disease the focus of life, having self-love and a love of life, being tolerant, being able to direct their own life, knowing how to laugh, accepting the past, and being observant, all of which affect the patient's reactions after receiving the diagnosis and their approach to the treatment process.[11]

One reason is that biomedical training is often emphasized during physician and nurse education, whereas training in ethical knowledge and effective communication methods usually falls short of expectations. In addition, not knowing how to address and manage the emotional reactions of patients and their relatives (depending on their cultural background) and believing that they cannot answer questions about the future can also be counted among the reasons. The fear of destroying the patient's hope, the fear of being blamed, and even the concern that patients may commit suicide cause healthcare professionals to experience difficulties. These factors make physicians feel extremely tense, especially when breaking bad news, and lead them to avoid this challenging task.[6] Table 1 illustrates the factors that influence the delivery of bad news in oncology.[17–20]

The Ethical and Legal Dimension of Breaking Bad News

Ethical Dimension

The fundamental philosophy of medicine is to prioritize the well-being of the patient. Nursing, as a care-oriented profession, likewise focuses on the well-being of the patient. Both professions strive to preserve life. Yet, while trying to save the patient from death, telling or making the patient feel that "you will die" through bad news contradicts the basic philosophy of medicine and nursing.

One of the most fundamental principles of medical ethics is autonomy, which encompasses a patient's ability to make decisions about their own body and act in accordance with their own will. To respect patient autonomy, physicians are responsible for clearly conveying all necessary information, including potential side effects, benefits, and risks, in a way patients can understand, thereby enabling informed decision-making about their diseases, diagnoses, and treatment options. This practice is called "informed consent." In addition, telling the truth to the patient and building trust afterward are critical ethical concepts.

Table 1. Factors affecting the delivery of bad news in oncology[17–20]

- Factors affecting the delivery of bad news in oncology
  - Patient-related factors
    - Age
    - Patient's health status (metastasis, terminal stage, prognosis, treatment)
    - Cultural background
    - Socioeconomic status
    - Level of knowledge
    - Desire to know/not know the truth
    - Process of accepting the illness
    - Marital status
    - Parental status
    - Life values (expectations, attitude, perception of death, denial)
    - Expected life span
  - Factors related to the patient's relatives
    - Sociocultural level
    - Level of knowledge
    - Intervention by the patient's relatives
  - Factors related to healthcare professionals
    - Cultural background
    - Fear of harming the patient
    - Training in delivering bad news
    - Attitude toward cancer
    - Professional experience
    - Trust relationship
  - Organization-related factors
    - Institutional resources (suitable environment, etc.)
    - Time constraints (physician/patient ratio)
    - Negative aspects of the healthcare system
    - Barriers to interdisciplinary practice

Respect for Patient Autonomy and Informed Consent

Autonomy, in the ethical sense, means making decisions about oneself based on one's values.[21] One of the aims of healthcare is to protect the autonomy of individuals by eliminating disease or reducing its impact. For this reason, respecting autonomy has become a central ideal in today's health services and is considered one of the key bioethical principles. Healthcare professionals regard respect for autonomy as a fundamental ethical responsibility and integrate it into their professional practice.[22]

Patients have a fundamental right to reliable and necessary information about their disease. However, this approach may differ across cultures. For example, while Western societies strongly advocate for patient autonomy and the right to be informed about their medical condition, regardless of the disease's severity or prognosis, Eastern societies emphasize the vital role of the family's perspective in patient management and decision-making, which creates a cultural and ethical dilemma.[23]

Another factor affecting patient autonomy is the physician's approach to the patient. Paternalism is the belief that a physician has the right and duty to decide on a patient's treatment. This approach has declined as human rights and patient rights have evolved, shifting the relationship toward mutual participation and two-way communication.[24] Today, patients often view the physician as a counsellor or guide and adopt the perspective that they have the right to choose and determine their own destiny.[25]

There are debates about patient autonomy and its feasibility in oncology. One issue is that patients lack the necessary level of medical knowledge and cannot be expected to fully comprehend the expertise required to make informed clinical decisions. Another concern is that patients may struggle to receive and retain information about their health status.[26] Autonomy may also conflict with the principle of beneficence and at times overshadow patient benefit. Therefore, the principles of autonomy and beneficence should be considered within their specific context.

Respecting the patient's autonomy in oncology is only possible by informing them about the relevant diagnosis, treatment, and care. In medical ethics, this process is referred to as informed consent. During informed consent, all information that a patient may want or need to know should be provided. The key aspect of informed consent is explaining the procedure in language the patient understands and ensuring they comprehend it.[27] It is only possible for the patient to make the most appropriate decision for their benefit if they know the nature of the cancer treatment, the causes of their disease, and the limits and scope of the treatment.[28] Autonomy may be temporarily limited by the disease itself, as well as by non-transient factors such as the societal context in which the person lives or their cognitive capacity. Cancer being a fatal disease, limits patient autonomy particularly in the context of whether the diagnosis is disclosed.

The patient's right to information is one of the most frequently emphasized ethical issues within the scope of patient rights. This right underscore personal freedom and dignity. According to the Patient Rights Regulation (2019) on informing patients, they have the right to determine their destiny, to make decisions freely, to request the protection of medical confidentiality, and to prevent their information from being shared without their consent. When patient information is evaluated in the context of breaking bad news, it may be considered permissible as "the patient may not be informed" if informing the patient would harm their health, according to the statement in the Patient Rights Regulation: "It is permissible to withhold the diagnosis in cases where there is a possibility that the disease may worsen by adversely affecting the patient's moral state, and where the course and outcome of the disease are considered grave."[29] However, withholding information from the patient is acceptable only in exceptional cases. Whether or not the patient is informed about their health status depends on the physician's discretion within the framework of the prevailing conditions. Otherwise, applying the same approach to every patient diagnosed with cancer is considered a violation of the patient's human rights. In some cases, ethical principles and legal practices worldwide can create dilemmas for healthcare professionals regarding disclosure. The appropriate approach in oncology is to communicate bad news in the best interests of the patient.

Truth-telling and Trust

Telling the truth or "not lying" is one of the principles that healthcare professionals must follow to establish and maintain a healthy relationship with patients.[30] In ethics, truth-telling refers to the process of providing accurate information to patients. Disclosing the truth about a patient's diagnosis is not only an ethical issue but also a moral responsibility for healthcare professionals.

Truth-telling in oncology can be evaluated from two perspectives. First, patients expect the physician to be truthful about their condition. Second, it is both the patient's legal right and the physician's duty. A better approach, however, is to inform the patient of the truth while managing the process by asking questions such as what, how much, how, and under what circumstances the patient wishes to know.

Informing patients is often not difficult, but situations may arise that legally and ethically challenge healthcare professionals. In oncology, information may be withheld if disclosure of the diagnosis is believed to cause harm or suffering. The Patient Rights Regulation (2019) states that information can be withheld in cases where healthcare professionals believe it will cause severe damage to the patient;[29] however, the limits of this provision are not clearly defined. What constitutes likely harm is ambiguous and may vary from person to person. Some studies have examined why physicians do not always tell the truth to patients; researchers have attributed this to altruism,[31] and it has also been noted that there is uncertainty about what exactly and how much should be disclosed,[32] and that it may even be considered morally acceptable to withhold the truth in order to benefit patients.[33]

The underlying rationale for not telling the truth to cancer patients is the belief that they may not be able to cope with the information, may develop psychological problems, and that the prognosis of the disease could worsen as a result. However, informing the patient at every stage of the disease is crucial for maintaining harmony between the patient and the physician or nurse. Once a physician is found to be lying, their ability to treat the patient effectively may be significantly reduced.

Practices regarding the disclosure of a cancer diagnosis to patients have varied throughout history. Research studies conducted in the 1950s and 1960s revealed that physicians were reluctant to tell patients the truth about their diagnosis and prognosis, and often withheld cancer diagnoses from patients.[34] At that time, one of the reasons for not disclosing a cancer diagnosis was the emotional reaction of patients and their relatives, as well as the widespread association of cancer with death.[35] However, over the last 40–50 years, researchers have emphasized the importance of breaking bad news to patients, regardless of the reason.[36] One supporting view is that effectively communicating information to patients can reduce, rather than increase, their anxiety and distress.[37] In other words, because lack of information and uncertainty are associated with higher levels of anxiety, it is emphasized that patients should be told the truth under all circumstances.[38]

Withholding the diagnosis from terminally ill patients has traditionally been considered a way to benefit the patient. In such cases, traditional medical practice and patients' relatives often disagree on this issue. Physicians may prefer to share a poor diagnosis with the patient's relatives rather than the patient. This practice, believed to protect the patient, stems from fears that the patient may deteriorate, become depressed, harm themself, or refuse treatment upon learning the diagnosis. However, these concerns belong to the physician and the patient's relatives, not the patient. Withholding the truth not only negatively affects treatment but also undermines respect for the patient's values. The medical information held by the physician is ultimately the patient's information. In particular, cancer patients have both the right to know their diagnosis and the right to prevent disclosure of their diagnosis to relatives.[9,10]

Developments in diagnostic and therapeutic methods, changes in social and cultural attitudes toward cancer, shifting perspectives on death, and, most importantly, the informed consent process within the framework of patient rights and respect for autonomy have all contributed to changes in how diagnoses are disclosed. Although informing the patient of a medical diagnosis may initially cause sadness and distress, the patient should be told and allowed to decide on their treatment. Undoubtedly, the patient's acceptance of and participation in treatment, following their understanding of their medical condition, will have a positive impact on the process. When a patient is unaware of the truth or misled, they may evaluate the situation differently, which can negatively impact their recovery. By contrast, after some time patients tend to focus on their treatment once they learn their diagnosis. For example, it becomes more challenging to explain surgery, chemotherapy, or radiotherapy to a patient whose cancer diagnosis has been concealed. Even when the diagnosis is initially withheld, patients may sometimes learn it from a clinic nurse or laboratory staff, in which case they may feel betrayed and develop mistrust.

Providing accurate information to the patient helps prevent anxiety, hopelessness, fear, depression, and insomnia, while also establishing a relationship of trust with healthcare professionals.[39] Telling the truth is also essential for patients to make informed plans.[22] When healthcare providers do not provide accurate information, it can lead to reluctance to participate in medical treatment in oncology.[40] A review of the legal situation shows that patients have the right to be informed about their medical diagnosis under various declarations.

In their ethical codes, the American Nurses Association[41] and the American Medical Association[42] emphasize that healthcare providers must tell the truth and avoid deceiving or misleading patients. At this point, it should not be forgotten that even if the news is bad, it is the patient's most fundamental right to receive information about their condition and future treatment options. The right to information is also defined in Article 7 of the World Medical Assembly Declaration of Patients' Rights.[43]

When examining national regulations, the patient's right to information is supported by law through biopolitical documents such as the *Medical Deontology Regulation* (1960)[44] and the *Code of Professional Ethics of the Turkish Medical Association*.[45] In addition, Article 15 of the Regulation on Patient Rights, which entered into force in 1998 and was amended in 2019, clearly defines the right to receive information about one's health status.[29] In this context, all the above-mentioned declarations and legal regulations emphasize the patient's right to know; thus, it is concluded that physicians should share the diagnosis. Furthermore, it has been reported that patients who are informed correctly, whose treatment options are clearly explained, whose choices are respected, who can easily access their physician, and who are cared for after the diagnosis adapt better to the process.[11]

Legal Responsibility

The legal aspect of breaking bad news is of particular concern to physicians and nurses in the context of professional responsibility. The most senior physician who knows the patient best, has a good working relationship with them, and has established a trust-based rapport should be the one to deliver bad news. It is also essential that physicians are equipped with the knowledge to answer questions from patients and their relatives.[2]

In addition to the physician, other healthcare professionals involved in the patient's care should also be informed about the patient's process. In particular, nurses need to provide consistent responses to questions asked by patients and their relatives, thereby maintaining trust and supporting a positive progression of the process. However, since the importance of teamwork is not fully internalized, this principle is often not adequately reflected in practice.

Although there is no statement in the *Nursing Law*[46] or *Nursing Regulation*[47] regarding nurses disclosing a diagnosis to patients, nurses, who are active members of the healthcare team, provide information to patients and their relatives about diseases and must communicate with patients who want to learn the facts about their condition. In Türkiye, nurses do not have a formal duty or responsibility to disclose diagnoses within the framework of their job descriptions, yet they frequently receive requests from patients and their relatives in this regard.

Studies in the literature indicate that, among healthcare disciplines, nurses carry the highest workload in providing direct care to patients and their families.[48] This means that regardless of the setting—whether in an inpatient unit, intensive care unit, outpatient clinic, or primary care unit—nurses are present for patients and their relatives as part of an interdisciplinary team during and after the delivery of bad news. Especially in Europe and America, nurses working as *specialized nurses* can undertake the task of breaking bad news to patients and their families. However, although the concept of *expert nurses* exists in Türkiye under the *Nursing Regulation*,[47] the type of information that they may provide to patients, particularly regarding authorization to disclose bad news, is not specified.

In Türkiye, the type of information provided to patients and their relatives about the patient's condition is generally not shared with other team members, except physicians. As a result, nurses in particular, may find themselves in difficult situations when faced with questions from patients or relatives. Since they are often unsure what the patient or their relatives know about the diagnosis and disease process, they may worry that discrepancies in their responses could mislead the patient. For this reason, nurses responsible for patient care must be aware of the information communicated to patients to prevent distress. This is because they may not be able to answer patients' questions or may risk inconsistencies with previously provided information.

Traditionally, breaking bad news has been the responsibility of physicians and is a stressful task. However, research has shown that it should be handled through interdisciplinary teamwork and that nurses are often involved in this process.[49] When they are not included and are unfamiliar with the patient's process, they face many difficulties. Even though nurses have no legal responsibility to break bad news in our country, it is necessary for them—given that they ensure continuity of care, are familiar with all aspects of the patient's condition, and are among the most trusted by patients and their families—to be present when bad news is delivered.

Approaches to Breaking Bad News

It is challenging to tell the truth without extinguishing the patient's hope. Several factors contribute to maintaining a patient's hope, including the stage and type of cancer, the patient's age, their perspective on the disease, and the availability of treatment options. Cultural factors are also decisive. In Africa, for example, cancer is associated with the black scourge, a hidden, damaging, and insidious disease. Italians perceive it as a condition that threatens both social and physical deterioration as well as death. In the United States, on the other hand, cancer is sometimes regarded as a personal failure or responsibility, rooted in deeply ingrained individuality and the value placed on self-determination.[50] How such a heavily loaded diagnosis should be communicated is an important issue that requires emphasis in both theory and practice.

The difficulties faced by healthcare professionals, especially physicians, in communicating with cancer patients and their relatives stem from the severe losses associated with cancer, the threat and fear of death, intense anxiety, and grief. Physicians and nurses who are in constant interaction with patients and their families encounter difficulties and obstacles in communication. For example, identifying with terminally ill patients, becoming overly attached, and having to deliver bad news can be devastating for healthcare professionals. Overly optimistic or unrealistic expectations of patients and their relatives also pose challenges.

Effective communication is essential in breaking bad news. Since healthcare professionals often lack the necessary skills to deliver bad news to patients and their families, it is frequently not communicated effectively in clinical settings.[51] Communication in breaking bad news is not only the transfer of information but also an interaction with social and psychological dimensions. Information should therefore be provided consciously within the physician-patient-family triangle.

Body language also plays a role in this process. The physician should provide a detailed description of the diagnosis, clearly explain the diagnostic process, and use realistic expressions about the future. It is also important not to speak negatively about the treatment and to provide accurate information. This helps prevent the patient from receiving misinformation from others and strengthens communication.[11]

It is inevitable that communication-based problems will arise when breaking bad news. One such problem in approaching cancer patients is the physician's anxiety about death. To prevent avoidance behavior, physicians who break bad news should prepare themselves in advance. If the physician is unwell, unable to deliver the news due to their working environment, anticipates difficulty, or feels surprised and upset by the news, they should postpone the conversation until they are ready to communicate effectively.

Physicians should not give bad news on the spot or in a rush. Healthcare providers should arrange a quiet, calm place and time where the conversation will not be interrupted. The environment should be silent, with minimal distractions such as ringing phones or people constantly coming and going.[1,7]

Patients often remain silent when they receive the news. At such times, the physician should allow the patient to express themselves instead of consoling them. An empathic and sensitive approach, characterized by active listening, is the most beneficial behavior for the patient. If the patient is crying and expressing their feelings, the physician should wait without interrupting. Physicians and nurses should reassure the patient that their feelings and the difficulties of the process are understood.

Table 2. Protocols for breaking bad news*

Protocol	Process
Six-step protocol (Buckman, 1984)[57]	1. Prepare for the news and initiate the conversation
	2. Find out what the patient knows about their illness
	3. Find out how much the patient wants to know
	4. Share the bad news with the patient
	5. Respond to the patient's emotions
	6. Discuss treatment options/make a follow-up plan
SPIKES protocol (Baile et al., 2000)[58]	**S**etting: Prepare the environment and listen
	Perception: Assess the patient's perception of their condition
	Invitation: Ask how much information the patient wishes to receive and begin providing it
	Knowledge: Provide medical information clearly
	Emotions and empathy: Recognize the patient's emotions and respond to their reactions with empathy
	Strategy and summary: Develop a treatment plan and summary
ABCDE protocol (Vandekieft, 2001)[59]	**A**dvance preparation
	Build a relationship
	Communicate well
	Deal with patient and family reactions
	Encourage and validate emotions
BREAKS protocol (Narayanan et al., 2010)[60]	**B**ackground: Gather detailed information about the patient and illness and prepare yourself
	Rapport: Establish a relationship through effective communication
	Explore: Identify what the patient knows, what they want to know about their illness, and who they want to have by their side
	Announce: Start speaking with a short, clear, and understandable introductory statement
	Kindling: Allow the patient to express their emotional reactions
	Summarize: Summarize, provide treatment information, share contact details, and recommend accurate and scientific sources of information

*Used with permission from Yamaç.

The patient should be allowed to ask questions. After the diagnosis, they should also be informed that they have the right to terminate treatment at any time, along with the benefits and side effects of the available treatment options. Both the patient and their relatives should be encouraged to ask questions, and healthcare professionals should answer honestly.[7]

Nurses play a crucial role in disclosing bad news and in the subsequent process, as they are more frequently in contact with patients and their families.[52] The physician must make the medical diagnosis, but nurses have great responsibility in maintaining a trusting relationship with the patient. They ensure continuity of care, follow all patient outcomes, remain in close contact after bad news is given, and communicate with the patient and their relatives about the realities of the disease. Therefore, most patients want their diagnosis to be confirmed by nurses and seek answers to many questions from them during the treatment process. The ethical responsibility of nurses in this regard is to act as patient advocates in the informed consent process.

Bad news must be delivered appropriately in oncology. Breaking bad news in oncology is a stressful task for physicians, but it is not a solitary responsibility; nurses are, and should be, frequently involved through interdisciplinary teamwork.[53] Patients and their families often prefer to meet with nurses for clarification, additional information, or confirmation of bad news. It is also important to note that oncology nurses can provide support for any emotional trauma that may arise in patients after receiving bad news.[54] Undoubtedly, effective communication is essential for maintaining a trusting relationship between the nurse and the patient.[55] The manner in which bad news is delivered can influence patient compliance with treatment, provide a clearer understanding of the recovery process and symptoms, reduce stress and anxiety, and ultimately increase overall patient satisfaction.[56]

Many factors related to physicians, nurses, patients, and their relatives can affect the process of breaking bad news and its aftermath. However, there are protocols to guide physicians and nurses in this process by providing a basic framework. The main protocols for breaking bad news are listed in the table below.[9] As shown in Table 2, all protocols follow a similar approach.[57–60] The common features of these approaches can be summarized as preparing an appropriate environment, gathering information, establishing empathetic communication, sharing the bad news, allowing the patient to express their feelings, and discussing the treatment process.

Conclusion

Breaking bad news is an inevitable aspect of oncology. To empower physicians and nurses in this regard, it is essential to incorporate a dedicated course on breaking bad news into the undergraduate curriculum and to strengthen these skills through various educational methods. In light of Hippocrates' principle, "*there is no disease, there is a patient*," a culturally specific, realistic, and truth-telling approach should be integrated into medical and nursing education. Culturally appropriate guidelines should be developed to better understand oncologists' perceptions of breaking bad news, reduce their stress and burnout, and enhance patient-physician and patient-nurse relationships during this process. Nurses, who often have to deliver bad news or respond to information requests from patients and their relatives, should be included in the process of reporting bad news, and their legal responsibilities should be reviewed, as they undertake invisible yet intense labor in this area. In addition, an interdisciplinary training model involving physicians, nurses, and psychologists/psychiatrists should be developed and adopted in practice.

Conflict of Interest: The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding: This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Author Contributions: Concept – Ş.G., S.Ş.; Design – Ş.G., S.Ş.; Supervision – S.Ş.; Data Collection and/or Processing - Ş.G.; Analysis and/or Interpretation - Ş.G.; Literature Review – Ş.G.; Writing – Ş.G.; Critical Review – S.Ş.

Peer-review: Externally peer-reviewed.

References

1. World Health Organization. Cancer Regional Profile 2020, Cancer Country Profile. Accessed August 20, 2024. https://www.who.int/teams/noncommunicable-diseases/surveillance/data/cancer-profiles
2. Ptacek JT, Eberhardt TL. Breaking bad news. A review of the literature. JAMA. 1996;276(6):496–502. [CrossRef]
3. Seifart C, Hofmann M, Bär T, Riera Knorrenschild J, Seifart U, Rief W. Breaking bad news-what patients want and what they get: evaluating the SPIKES protocol in Germany. Ann Oncol. 2014;25(3):707–711. [CrossRef]
4. Ptacek JT, Ptacek JJ. Patients' perceptions of receiving bad news about cancer. J Clin Oncol. 2001;19(21):4160–4164. [CrossRef]
5. Warnock C, Tod A, Foster J, Soreny C. Breaking bad news in inpatient clinical settings: role of the nurse. J Adv Nurs. 2010;66(7):1543–1555. [CrossRef]
6. Buckman R. How To Break Bad News: A Guide for Health Care Professionals. Maryland: The Johns Hopkins University Press;1992:123. [CrossRef]
7. Yamaç D, Bahadır D. Kötü Haber Verme. In: Yamaç D, Demirsoy N, Budakoğlu İ, Coşkun Ö, Gönüllü İ, eds. Tıpta İletişim Becerileri. Ankara: Hipokrat Kitabevi; 2020:153–166. Turkish.
8. Al-Bishi N. Truth-Telling: A Comparative Analysis of Cancer Diagnosis Disclosure Protocols in Western and Eastern Countries. Int J Novel Res Healthc Nurs. 2022;9(2):69–85.
9. Baliga MS, Prasad K, Rao S, et al. Breaking the Bad News in Cancer: An In-Depth Analysis of Varying Shades of Ethical Issues. Indian J Med Paediatr Oncol. 2022;43(03):226–232. [CrossRef]
10. Çay Şenler F. Ölüme Yakın Hasta ve Hasta Yakını ile İletişim. In: Yamaç D, Demirsoy N, Budakoğlu İ, Coşkun Ö, Gönüllü İ, eds. Tıpta İletişim Becerileri. Ankara: Hipokrat Kitabevi; 2020:167–174. Turkish.
11. Erözenci A. Bir Türk Filmi Olarak Kanser. 1st ed. Ayrıntı Yayınları; 2013.
12. Kazdaglis GA, Arnaoutoglou C, Karypidis D, Memekidou G, Spanos G, Papadopoulos O. Disclosing the truth to terminal cancer patients: a discussion of ethical and cultural issues. East Mediterr Health J. 2010;16(4):442–447. [CrossRef]
13. Aljubran AH. The attitude towards disclosure of bad news to cancer patients in Saudi Arabia. Ann Saudi Med. 2010;30(2):141–144. [CrossRef]
14. Guven T. Truth-telling in cancer: examining the cultural incompatibility argument in Turkey. Nurs Ethics. 2010;17(2):159–166. [CrossRef]
15. Fujimori M, Shirai Y, Asai M, Kubota K, Katsumata N, Uchitomi Y. Effect of communication skills training program for oncologists based on patient preferences for communication when receiving bad news: a randomized controlled trial. J Clin Oncol. 2014;32(20):2166–2172. [CrossRef]
16. Stiefel F, Krenz S. Psychological challenges for the oncology clinician who has to break bad news. In: Surbone A, ed. New Challenges in Communication with Cancer Patients. New York: Springer; 2013:51–62. [CrossRef]
17. Zekri J, Karim SM. Breaking Cancer Bad News to Patients with Cancer: A Comprehensive Perspective of Patients, Their Relatives, and the Public-Example from a Middle Eastern Country. J Glob Oncol. 2016;2(5):268–274. [CrossRef]
18. Massod J, Beenish Q, Zubia M, Shaukat AJ. Disclosure of cancer diagnosis: Pakistani patients' perspective. MEJC. 2010;1(2):89-94.
19. Tsoussis S, Papadogiorgaki M, Markodimitraki E, et al. Disclosure of cancer diagnosis: the Greek experience. J BUON. 2013;18(2):516–526.
20. Gül Ş. An Ethical Analysis of Physicians' and Nurses' Experiences of Breaking Bad News. Unpublished Master's Thesis. Ankara University Health Sciences Institute; 2023. Turkish.
21. Beauchamp T, Childress J. Principles of Biomedical Ethics. 8th ed. UK: Oxford University Press; 2009:208.
22. Baykara ZG, Şahinoğlu S. An evaluation of nurses' professional autonomy in Turkey. Nurs Ethics. 2014;21(4):447–460. [CrossRef]
23. Basheikh M. Preferences of the Saudi Population in Breaking Bad Medical News: A Regional Study. Cureus. 2021;13(11):e19525. [CrossRef]
24. Ehsani SR, Cheraghi MA, Nejati A, Salari A, Esmaeilpoor AH, Nejad EM. Medication errors of nurses in the emergency department. J Med Ethics Hist Med. 2013;6:11.
25. Dünya Tabipler Birliği. Tıp Etiği El Kitabı. 3rd ed. İstanbul: Türk Tabipler Birliği; 2015. Turkish.
26. Caplan AL. Why autonomy needs help. J Med Ethics. 2014;40(5):301–302. [CrossRef]
27. Tuckett AG. On paternalism, autonomy and best interests: telling the (competent) aged-care resident what they want to know. Int J Nurs Pract. 2006;12(3):166–173. [CrossRef]
28. Elçioğlu Ö, Demirhan Erdemir A. Klinik Uygulamalarda Her Durumda Ortaya Çıkan Etik Yükümlülükler. In: Klinik Etik. İstanbul: Nobel Tıp Kitabevleri; 2001:104–148. Turkish.
29. Hasta Hakları Yönetmeliği. 2019. Accessed October 1, 2025. https://www.mevzuat.gov.tr/mevzuat?MevzuatNo=4847&MevzuatTur=7&MevzuatTertip=5
30. Oğuz NY, Tepe H, Örnek Büken N, Kırımsoy Kucur D. Biyoetik Terimleri Sözlüğü. Türkiye Felsefe Kurumu; 2005:196–197. Turkish.
31. Everett JP, Walters CA, Stottlemyer DL, Knight CA, Oppenberg AA, Orr RD. To lie or not to lie: resident physician attitudes about the use of deception in clinical practice. J Med Ethics. 2011;37(6):333–338. [CrossRef]
32. Heywood R, Macaskill A, Williams K. Informed consent in hospital practice: health professionals' perspectives and legal reflections. Med Law Rev. 2010 Spring;18(2):152–184. [CrossRef]
33. Elvish R, James I, Milne D. Lying in dementia care: an example of a culture that deceives in people's best interests. Aging Ment Health. 2010;14(3):255–262. [CrossRef]
34. Oken D. What to tell cancer patients. A study of medical attitudes. JAMA. 1961;175:1120–1128. [CrossRef]
35. Sokol DK. How the doctor's nose has shortened over time; a historical overview of the truth-telling debate in the doctor-patient relationship. J R Soc Med. 2006;99(12):632–636. [CrossRef]
36. Cox A, Jenkins V, Catt S, Langridge C, Fallowfield L. Information needs and experiences: an audit of UK cancer patients. Eur J Oncol Nurs. 2006;10(4):263–272. [CrossRef]
37. Fallowfield L, Ratcliffe D, Jenkins V, Saul J. Psychiatric morbidity and its recognition by doctors in patients with cancer. Br J Cancer. 2001;84(8):1011–1015. [CrossRef]
38. Higgs R. Truth-telling. In: Kuhse H, Singer P, eds. A Companion to Bioethics. London: Wiley-Blackwell; 2009:520–529. [CrossRef]
39. Managheb SE, Hosseinpour M, Mehrabi F. Patients' viewpoints about how to break bad news. Iranian J Med Ethics Hist Med. 2013;6(4):68–79.
40. 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 Manag Res. 2018;10:2173–2181. [CrossRef]
41. American Nurses' Association. The Code of Ethics for Nurses. 2015. Accessed December 16, 2024. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/
42. American Medical Association. Code of Medical Ethics. Accessed December 18, 2024. https://code-medical-ethics.ama-assn.org/chapters/patient-physician-relationships
43. World Medical Assembly (WMA) Declaration of Lisbon on the Right of the Patient, 2005. Accessed October 1, 2025. https://www.wma.net/wp-content/uploads/2005/09/Declaration-of-Lisbon-2005.pdf
44. Tıbbi Deontoloji Nizamnamesi. 1960. Accessed August 10, 2023. https://www.mevzuat.gov.tr/MevzuatMetin/2.3.412578.pdf
45. Türk Tabipler Birliği. Hekimlik Meslek Etiği Kuralları. 2012. Accessed September 20, 2014. https://www.ttb.org.tr/kutuphane/h_etikkural.pdf
46. Hemşirelik Kanunu 2007. Accessed November 10, 2024. https://www.mevzuat.gov.tr/mevzuat?MevzuatNo=6283&MevzuatTur=1&MevzuatTertip=3
47. Hemşirelik Yönetmeliği. 2010. Accessed November 10, 2024. https://www.mevzuat.gov.tr/mevzuat?MevzuatNo=13830&MevzuatTur=7&MevzuatTertip=5
48. Uveges MK, Milliken A, Alfred A. Role of the Critical Care Nurse in Disclosing Difficult News. AACN Adv Crit Care. 2019 Fall;30(3):287–293. [CrossRef]
49. Lackie K, Miller S, Brown M, et al. Interprofessional collaboration between health professional learners when breaking bad news: a scoping review of teaching approaches. JBI Evid Synth. 2024;22(6):1071–1102. [CrossRef]
50. Post SG. Encyclopedia of Bioethics. 4th ed. Gale Virtual Reference Library Macmillan Reference USA; 2014.
51. Hoffmann TC, Glasziou PP, Boutron I, et al. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. BMJ. 2014;348:g1687. [CrossRef]
52. Matthews T, Baken D, Ross K. Single cases from multiple perspectives: a qualitative study comparing the experiences of patients, patients' caregivers, surgeons, and nurses when bad news is delivered about cancer. J Psychosoc Oncol Res Pract. 2020;2(3):e32. [CrossRef]
53. Bumb M, Keefe J, Miller L, Overcash J. Breaking Bad News: An Evidence-Based Review of Communication Models for Oncology Nurses. Clin J Oncol Nurs. 2017;21(5):573–580. [CrossRef]
54. Aungst H. Delivering bad news: Helping your patients retain dire details. Modern Medicine Network. 2009. Accessed October 1, 2025. https://www.contemporarypediatrics.com/view/delivering-bad-news-helping-your-patients-retain-dire-details
55. Mishelmovich N, Arber A, Odelius A. Breaking significant news: The experience of clinical nurse specialists in cancer and palliative care. Eur J Oncol Nurs. 2016;21:153–159. [CrossRef]
56. Parker PA, Baile WF, de Moor C, Lenzi R, Kudelka AP, Cohen L. Breaking bad news about cancer: patients' preferences for communication. J Clin Oncol. 2001;19(7):2049–2056. [CrossRef]
57. Buckman R. Breaking bad news: why is it still so difficult? Br Med J (Clin Res Ed). 1984;288(6430):1597–1599. [CrossRef]
58. 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. Oncologist. 2000;5(4):302–311. [CrossRef]
59. VandeKieft GK. Breaking bad news. Am Fam Physician. 2001;64(12):1975–1978.
60. Narayanan V, Bista B, Koshy C. 'BREAKS' Protocol for Breaking Bad News. Indian J Palliat Care. 2010;16(2):61–65. [CrossRef]