



Original Article

Comparison of Healthcare Providers' Practices and Patients' Attitudes Toward Breaking Bad News: A Single-Center Study

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Received: 10 Jan. 2026

Revised: 28 Feb. 2026

Accepted: 22 Mar. 2026

Published: 23 May. 2026

Article Info

Keywords:

Health Personnel,
Patients,
Attitude,
Professional Practice,
Truth Disclosure.

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How to Cite This Article:

Abdulriha KA, Bagheri saveh
MI, Jasim AM, Vatandost S.
Comparison of Healthcare
Providers' Practices and
Patients' Attitudes Toward
Breaking Bad News: A Single-
Center Study. Prev Care Nurs
Midwifery J. 2026;16(2):60-69.

Abstract

Background: Breaking bad news (BBN) is a challenging communication process that requires skill, training, and sensitivity to patients' cultural values. However, limited evidence exists on whether healthcare providers' practices align with patients' attitudes.

Objectives: This study aimed to compare healthcare providers' practices with patients' attitudes regarding the delivery of bad news.

Methods: This cross-sectional study was conducted at Marjan Hospital in Babylon, Iraq, from September to October 2025. A total of 167 hospitalized patients who had received bad news were recruited using quota sampling. Data were collected through a demographic questionnaire and two self-report questionnaires assessing healthcare providers' performance and patients' attitudes toward breaking bad news. The data were entered into SPSS version 21 and analyzed using descriptive statistics and Pearson's correlation coefficient.

Results: The mean (SD) scores for healthcare providers' performance and patients' attitudes were 8.97 (2.01) out of 19 and 62.19 (2.30) out of 76, respectively. No significant correlation was found between the total scores of healthcare providers' performance and patients' attitudes ($r = -0.14$, $p = 0.14$), although significant correlations were observed for several individual items.

Conclusion: The findings showed significant differences between patients' attitudes and healthcare providers' performance in several aspects of breaking bad news. These findings highlight the need for educational programs and culturally sensitive communication strategies to better align clinical practice with patients' preferences.

Implications for Nursing and Midwifery Preventive Care

- The identified gaps between healthcare providers' performance and patients' attitudes highlight the need for communication training tailored to patients' preferences in preventive nursing care.
- Using perspectives to guide communication practices may improve the quality of preventive nursing care and patient-centered interactions during bad news delivery.



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Introduction

Bad news is defined as any information or situation that causes individuals to perceive hopelessness, limitations in future life choices, and threats to their mental and physical well-being [1]. Examples of bad news reported in previous studies include the need for surgery, unfavorable clinical and para-clinical test results, loss of a limb, cancer, AIDS, and chronic illnesses [2, 3]. Breaking bad news is a complex communication process that requires appropriate skills to minimize its negative effects on patients, their families, and their future relationships with healthcare professionals [4]. Inappropriate delivery of bad news may lead to stress, misunderstanding of the diagnosis, treatment, and prognosis of the disease, and ultimately unfavorable outcomes [5]. Conversely, delivering bad news appropriately can reduce unrealistic expectations, disappointment, and confusion, while enabling patients to make informed decisions about their treatment and participate actively in their care [6].

Breaking Bad News is a collaborative process that should involve the healthcare team rather than being the sole responsibility of a single provider. However, because communication skills related to breaking bad news are often inadequately addressed in healthcare education, healthcare providers frequently rely on personal experience or observation of senior colleagues, which may increase the likelihood of inappropriate communication practices [7]. The results of a 2024 review of healthcare providers' experiences and perspectives on breaking bad news showed that the major barriers identified by healthcare providers were limited awareness of bad news protocols and inadequate training [8]. The results of a study by Al-Sabawi et al. showed that 63% of physicians were unfamiliar with bad news protocols and only 37% of physicians had sufficient knowledge of these protocols [9]. Another study in Iraq showed that 67% of healthcare providers had no experience receiving training in delivering bad news, only about 9% had academic training, and 4% had in-service training in breaking bad news. Furthermore, nearly 72% were not aware of the SPIKES protocol, one of the most well-known guidelines for Breaking Bad News [10].

Breaking Bad News is highly influenced by cultural norms, values, and societal beliefs [11]. Therefore, understanding the patients' preferences regarding how bad news should be communicated is essential for effective communication [12]. There are different views on telling the truth and breaking bad news across different cultures and societies. Patients' preferences regarding the delivery of bad news may differ significantly across cultures; therefore, cultural and social differences should be taken into account when breaking bad news [13]. In the study by Rao et al., most patients wanted to be informed about their cancer diagnosis, and the majority also wanted their families to participate in this process [14]. The factors considered important by patients and their families when receiving bad news include privacy, sufficient time without interruption, clarity and honesty in providing information, and an empathetic and caring attitude [15].

The results of a study by Gholami et al. in Iran showed significant differences between patients' attitudes and healthcare providers' performance in delivering bad news, indicating that the delivery of bad news was not aligned with patients' preferences [16].

In general, breaking bad news is a critical aspect of communication between healthcare providers and patients, requiring consideration of both patients' preferences and healthcare providers' competencies to optimize communication outcomes. Therefore, aligning patients' expectations with healthcare providers' practices is essential to reduce negative emotional reactions and improve trust and satisfaction with healthcare services. Assessing the alignment between healthcare providers' practices and patients' attitudes may help inform patient-centered communication in preventive nursing care. Given the limited evidence from Iraq, this study was conducted to compare healthcare providers' performance with patients' attitudes toward breaking bad news.

Objectives

The present study aimed to compare healthcare providers' performance with patients' attitudes toward breaking bad news.

Methods

Study Design

This cross-sectional study was conducted at Marjan Hospital in Babylon, Iraq, between September and October 2025.

Participants & Sampling

The study population consisted of hospitalized patients admitted to Marjan Hospital in Babylon, Iraq. Based on the cross-sectional design and data from a previous study [16], the minimum required sample size was estimated to be 135 participants, assuming a two-sided significance level of 5% ($\alpha = 0.05$), a statistical power of 90% ($1-\beta = 0.90$), and an expected correlation coefficient of 0.275. To increase statistical power and compensate for potential missing data, 167 participants were ultimately included.

Participants were recruited using quota sampling proportional to the number of patients admitted to internal medicine, surgery, neurology, Oncology, and cardiology wards. Within each ward, participants were selected using convenience sampling.

The inclusion criteria were receipt of bad news during the current hospitalization (defined as an incurable disease, need for surgery, myocardial infarction, need for transfer, amputation, cancellation of surgery, CVA, Medication shortage, Hepatitis), age ≥ 18 years, orientation to time and place, and stable hemodynamic status. Questionnaires with incomplete responses were excluded from the final analysis.

Measurement Instruments

Data were collected using three instruments: a demographic information form, a questionnaire assessing healthcare providers' performance in breaking bad news, and a questionnaire evaluating patients' attitudes toward breaking bad news.

The performance questionnaire, developed and psychometrically validated by Gholami et al. (2023) in Iran (18), consists of 19 dichotomous items (Yes = 1, No = 0), with total scores ranging from 0 to 19. Higher scores indicate greater adherence to recommended practices for breaking bad news [16].

The attitude questionnaire, developed and validated by Labaf et al. (2015), includes 19 items rated on a five-point Likert scale (0 = strongly disagree to 4 = strongly agree), yielding total scores ranging from 0 to 76. Higher scores indicate more favorable attitudes toward the delivery of bad news [17].

Both questionnaires were translated into Arabic using the forward-backward translation method by two independent bilingual specialists. After reconciliation of the translated versions, the final Arabic version was submitted to the original instrument developer for approval. 10 patients and 10 experts assessed face validity. Content validity was evaluated qualitatively for cultural adaptation and quantitatively using the content validity ratio (CVR = 0.87) and content validity index (CVI = 0.89). Reliability was assessed in a pilot study involving 30 participants using Cronbach's alpha, yielding coefficients of 0.84 for the performance questionnaire and 0.88 for the attitude questionnaire.

Data Collection Procedure

Before data collection, the study objectives were explained to all participants, and written informed consent was obtained. Data were collected by the first author during morning, evening, and night shifts.

Statistical Analysis

Data were analyzed using SPSS version 21 (IBM Corp., Armonk, NY, USA). The Shapiro-Wilk test indicated that both performance scores ($p = 0.11$) and attitude scores ($p = 0.08$) were normally distributed. Descriptive statistics, including frequency, mean, and standard deviation, were used to summarize the data. Independent-samples t-test, one-way analysis of variance (ANOVA), and Pearson's correlation coefficient were applied for inferential analyses, as appropriate.

Result

The mean (SD) age of the participants was 51.3 (14.0) years, and 51.5% were female. Most participants were married (74.3%) and illiterate (52.0%). No significant differences in attitude scores toward breaking bad news were observed according

to gender, education level, marital status, occupation, hospital ward, or type of bad news (all $p > 0.05$). In addition, age was not significantly correlated with attitude scores ($r = 0.11$, $p = 0.22$) [Table 1].

The mean (SD) healthcare providers' performance score for breaking bad news was 8.97 (2.01) out of 19 (95% CI: 8.66–9.28). Detailed item scores are presented in Table 2.

The mean (SD) total attitude score toward breaking bad news was 62.19 (2.30) out of 76 (95% confidence interval [CI]: 61.84–62.54). Among the questionnaire items, the highest mean score was

observed for the preference to receive bad news in a private setting, 3.89 (0.26). In contrast, the lowest mean score was related to the preference for being informed only about the diagnosis without receiving information about the prognosis or outcomes, 1.09 (0.16) [Table 3].

Pearson's correlation analysis showed no significant correlation between the total healthcare providers' performance score and the total patients' attitude score ($r = -0.14$, $p = 0.14$). However, significant correlations were observed for several individual questionnaire items, whereas others showed no statistically significant association [Table 4].

Table 1. Demographic and Clinical Characteristics of the Participants and Comparison of Attitude Scores toward Breaking Bad News (N = 167)

Variable	Category	n (%) / M (SD)	Attitude Score, M (SD)	<i>p</i>
Age (years)	—	51.3 (14.0)	—	$r = 0.11$ $p = 0.22$
Gender	Male	81 (48.5)	63.88 (3.81)	0.215
	Female	86 (51.5)	62.22 (2.68)	
Education	Illiterate	87 (52.0)	64.11 (2.75)	0.170
	Read and write	2 (1.2)	63.21 (1.68)	
	Secondary	30 (18.0)	62.45 (2.66)	
	Diploma	18 (10.8)	61.01 (2.59)	
	University	30 (18.0)	63.40 (2.81)	0.510
Marital status	Single	5 (3.0)	62.41 (2.51)	
	Married	124 (74.3)	63.22 (2.42)	
	Widowed	38 (22.8)	62.11 (2.78)	
Occupation	Government employee	76 (45.5)	61.01 (2.59)	0.090
	Non-government employee	11 (6.6)	63.40 (2.81)	
	Unemployed	32 (19.2)	62.41 (2.51)	
	Housewife	48 (28.7)	61.01 (2.59)	
Hospital ward	Internal medicine	37 (22.2)	63.22 (2.68)	0.100
	Surgery	33 (19.8)	65.11 (2.75)	
	Oncology	30 (18.0)	63.21 (1.68)	
	Neurology	34 (20.4)	62.45 (2.66)	
	Cardiology	33 (19.8)	68.22 (2.68)	0.070
Type of bad news	Myocardial infarction	27 (16.2)	61.01 (2.59)	
	Cancer	23 (13.8)	63.40 (2.81)	
	Canceled surgery	15 (9.0)	62.41 (2.51)	
	HIV	3 (1.8)	63.22 (2.42)	
	Need for surgery	21 (12.6)	62.11 (2.78)	
	Medication shortage	7 (4.2)	61.01 (2.59)	
	Paralysis	12 (7.2)	63.40 (2.81)	
	COVID-19	10 (6.0)	62.41 (2.51)	
	Hepatitis	14 (8.4)	61.01 (2.59)	
	Need for transfer	9 (5.4)	63.22 (2.68)	
	Amputation	5 (3.0)	65.11 (2.75)	
	Cerebrovascular accident (CVA)	21 (12.6)	62.01 (2.59)	

Note. Data are presented as M (SD) for continuous variables and n (%) for categorical variables. The association between age and attitude score was examined using Pearson's correlation coefficient. Comparisons between two groups were performed using the independent samples t-test, and comparisons among three or more groups were performed using one-way analysis of variance (ANOVA). CVA = cerebrovascular accident; HIV = human immunodeficiency virus.

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Table 2. Healthcare Providers' Performance in Breaking Bad News (N = 167)

Item	M (SD)
1. Did you receive the bad news in a private environment (e.g., a private room)?	0.08 (0.25)
2. Was a family member or friend present when the bad news was delivered?	0.86 (0.31)
3. Did the healthcare provider maintain eye contact while delivering the bad news?	0.56 (0.30)
4. Did the healthcare provider use physical contact (e.g., placing a hand on your shoulder) to express empathy while delivering the bad news?	0.22 (0.11)
5. Was an appropriate time arranged before the bad news was delivered?	0.09 (0.14)
6. Were you asked how much you already knew about your illness before receiving the bad news?	0.21 (0.13)
7. Were you asked whether you wished to receive the bad news?	0.53 (0.10)
8. Were introductory phrases such as "I have some bad news to share with you" used before delivering the bad news?	0.48 (0.21)
9. Was the bad news delivered gradually?	0.39 (0.19)
10. Was the bad news first delivered to your companions, who then informed you?	0.51 (0.16)
11. After delivering the bad news, did the healthcare provider summarize the information to ensure your understanding?	0.11 (0.18)
12. Did the healthcare provider introduce themselves before delivering the bad news?	0.67 (0.13)
13. After delivering the bad news, were you encouraged to express your thoughts and feelings?	0.50 (0.21)
14. Were the consequences of the bad news explained after it was delivered?	0.71 (0.16)
15. Did the healthcare provider use religious or spiritual expressions while delivering the bad news?	0.72 (0.22)
16. Was the bad news delivered by a healthcare provider directly involved in your treatment?	0.59 (0.32)
17. Were you given an opportunity to speak after receiving the bad news?	0.88 (0.16)
18. Was the bad news delivered in a clear, straightforward, and honest manner?	0.51 (0.15)
19. Was the bad news delivered in your native language?	0.85 (0.19)
Total score (0–19)	8.97 (2.01)

Note. Responses were scored as Yes (1) and No (0). Total scores ranged from 0 to 19, with higher scores indicating better adherence to recommended practices for breaking bad news. Values are presented as M (SD).

Table 3. Patients' Attitudes toward Breaking Bad News (N = 167)

Item	M (SD)
1. I prefer to receive bad news in a private setting (e.g., a private room).	3.89 (0.26)
2. I prefer to have a family member or friend present when receiving bad news.	3.66 (0.45)
3. I prefer the healthcare provider to maintain eye contact while delivering bad news.	3.45 (0.63)
4. I prefer the healthcare provider to express empathy through appropriate physical contact (e.g., touching my hand or shoulder), within cultural and religious boundaries.	3.01 (0.79)
5. I prefer the healthcare provider to allocate sufficient time before delivering bad news.	3.81 (0.75)
6. I prefer the healthcare provider to assess what I already know about my condition before delivering bad news.	3.64 (0.68)
7. I prefer to be asked whether I wish to receive the bad news before it is delivered.	3.09 (0.46)
8. I prefer the healthcare provider to give a warning before delivering bad news (e.g., "I have some bad news to share with you.").	3.88 (0.63)
9. I prefer to receive bad news gradually.	3.49 (0.63)
10. I prefer to receive bad news through a family member or friend.	1.16 (0.11)
11. I prefer the healthcare provider to summarize the information at the end of the discussion, regardless of my emotional state.	3.36 (0.50)
12. I prefer the healthcare provider to introduce themselves before delivering bad news.	3.87 (0.64)
13. I prefer to be encouraged to express my feelings after receiving bad news.	3.10 (0.27)
14. I prefer to be informed only about the diagnosis and not the prognosis or expected outcomes.	1.09 (0.16)
15. I prefer the healthcare provider to use religious or spiritual expressions when delivering bad news.	3.01 (0.60)
16. I prefer to receive bad news from the physician responsible for my care, even if they are less experienced.	3.88 (0.17)
17. I prefer the healthcare provider to allow sufficient time for me to ask questions after delivering bad news.	3.73 (0.60)
18. I prefer bad news to be delivered directly and honestly.	3.20 (0.47)
19. I prefer to receive bad news in my native language.	3.87 (0.50)
Total score (0–76)	62.19 (2.30)

Note. Items were rated on a 5-point Likert scale ranging from 0 (strongly disagree) to 4 (strongly agree). Total scores ranged from 0 to 76, with higher scores indicating a stronger preference for receiving bad news under recommended communication conditions. Values are presented as M (SD).

Table 4. Correlation between Healthcare Providers' Performance and Patients' Attitudes toward Breaking Bad News (N = 167)

Item	Performance M (SD)	Attitude M (SD)	<i>r</i>	<i>p</i>
1	0.08 (0.25)	3.89 (0.26)	-0.34	0.020
2	0.86 (0.31)	3.66 (0.45)	0.29	0.030
3	0.56 (0.30)	3.45 (0.63)	-0.10	0.100
4	0.22 (0.11)	3.01 (0.79)	0.19	0.010
5	0.09 (0.14)	3.81 (0.75)	-0.11	0.090
6	0.21 (0.13)	3.64 (0.68)	-0.41	0.020
7	0.53 (0.10)	3.09 (0.46)	-0.24	0.020
8	0.48 (0.21)	3.88 (0.63)	0.18	0.110
9	0.39 (0.19)	3.49 (0.63)	-0.17	0.040
10	0.51 (0.16)	1.16 (0.11)	0.21	0.090
11	0.11 (0.18)	3.36 (0.50)	-0.27	0.010
12	0.67 (0.13)	3.87 (0.64)	0.11	0.080
13	0.50 (0.21)	3.10 (0.27)	0.09	0.070
14	0.71 (0.16)	1.09 (0.16)	0.12	0.010
15	0.72 (0.22)	3.01 (0.60)	0.21	0.010
16	0.59 (0.32)	3.88 (0.17)	0.22	0.030
17	0.88 (0.16)	3.73 (0.60)	0.16	0.070
18	0.51 (0.15)	3.20 (0.47)	0.13	0.210
19	0.85 (0.19)	3.87 (0.50)	0.61	0.010
Total score	8.97 (2.01)	62.19 (2.30)	-0.14	0.140

Note. Values are presented as M (SD). Pearson's correlation coefficient (*r*) was used to assess the association between healthcare providers' performance and patients' attitudes toward breaking bad news.

Discussion

This study aimed to compare healthcare provider performance and patients' attitudes toward breaking bad news. Healthcare providers adhered to less than half of the recommended practices for breaking bad news. In contrast, the overall attitude scores indicated a strong patient preference for receiving bad news according to the recommended principles. In the performance domain of the questionnaire, the lowest score was associated with maintaining privacy during bad news delivery, whereas this item received a high score in the attitude section. This discrepancy indicated a significant negative correlation, reflecting a mismatch between patients' expectations and healthcare providers' performance. Previous studies, including Gholami et al. [16], Amini et al. [18], and Nader et al. [19], consistently highlight patients' preference for receiving bad news in a private setting. Gholami et al. also reported a significant gap between patients' expectations and healthcare provider adherence to privacy during such conversations [17]. Violations of privacy not only contribute to increased anxiety and misconceptions but also undermine trust in medical healthcare providers. While ensuring privacy may be challenging in emergency contexts, in non-critical

situations, feasible solutions include using a private room, reducing environmental distractions, and adopting low-tone verbal communication to maintain confidentiality.

Regarding the patient's right to be informed, the item assessing whether providers inquired about the patient's current knowledge received a low score in the performance section. In contrast, the corresponding attitude score was high. These findings suggest that patients expect providers to assess their baseline understanding before offering detailed information. The difference was statistically significant and negatively correlated. Consistent findings from other studies reinforce the need for gauging patient knowledge before disclosure [20, 21]. Overuse of medical jargon further hinders effective communication [22, 23]. Thus, information should align with the patient's cognitive capacity and informational needs. Miscommunication, whether due to excessive, inadequate, or incomprehensible information, can exacerbate confusion and emotional distress. In the present study, the high rate of illiteracy among participants underscores the importance of tailoring communication accordingly. Berkey et al. emphasized that information needs vary with cultural, educational, and demographic factors,

all of which should guide communication strategies [24]. Gradual disclosure of bad news, another critical domain, received a low-performance score, while patients' attitude scores reflected a strong preference for such an approach. The discrepancy was statistically significant. This finding is supported by studies such as Nader et al. [19] and Gholami et al. [16], which reported that gradual delivery was among the most preferred communication styles. Evidence suggests that one-time disclosure is often inadequate and emotionally overwhelming for patients, impairing decision-making. Accordingly, a two-step communication strategy is recommended [25, 26]. It was also found that gradual delivery was among the most preferred communication styles. Abrupt disclosure can result in psychological trauma, confusion, reduced understanding, and even treatment avoidance. Structured communication protocols and targeted training for healthcare providers can mitigate these risks and enhance outcomes.

Another aspect with poor performance scores was scheduling a specific time for delivering bad news, which contrasted sharply with patients' strong preference for advance notice. Gholami et al. similarly found poor healthcare provider performance in this regard [16]. Warnock et al. reported that only 18.2% of patients had scheduled time slots for receiving bad news, often due to high workload and time constraints [4]. While emergencies may limit scheduling, non-urgent situations warrant prior coordination, allowing patients to involve family or trusted individuals for emotional support. Healthcare providers' performance in showing empathy and physical support also received low scores, despite patients' attitudes indicating a strong desire for compassionate communication. Nader et al. found that patients expect emotional consideration during bad news delivery [19]. Gholami et al. also highlighted inadequate performance in this domain [16]. In contrast, Guven et al. reported that 94% of patients valued emotional empathy from healthcare providers, though only 21% preferred physical contact [26]. Cultural and religious constraints in

Islamic countries like Iraq may limit cross-gender physical contact.

Nevertheless, verbal and non-verbal expressions of empathy remain viable and essential. Failing to convey empathy appropriately may result in resentment, emotional distress, and reduced patient satisfaction. Thus, empathetic communication within culturally acceptable boundaries should be prioritized. Summarizing information following the disclosure of bad news received a low-performance score, whereas the corresponding attitude score was high. This difference was statistically significant. Although Gholami et al. reported a similar trend, the difference in their study was not statistically significant [16]. According to the SPIKES [25] and BREAKS [27] protocols, summarizing is a critical final step in delivering bad news. It helps reduce confusion, reinforces key points, and encourages patient participation in care planning by facilitating better understanding and memory retention. In the attitude domain, one of the lowest-scoring items was the preference to receive bad news indirectly through a partner. This finding indicates that patients prefer direct communication from healthcare providers, particularly physicians. Studies by Gholami et al. [16], Krieger et al. [21], and Nader et al. [19] all reported similar findings. The ethical and legal consensus now affirms that patients have the right to full disclosure about their health status. Concealing information may erode trust and contradict bioethical standards, although such practices still occur in some settings. Given patients' strong preference for direct communication, healthcare providers are ethically obligated to ensure transparency during bad news delivery.

Another low-scoring item in the attitude section pertained to not discussing the consequences of bad news. This finding suggests that patients wish to be informed about the implications of their diagnosis. Similar findings were reported by Gholami et al. [16] and supported by studies such as Barikani et al. [22], Baile et al. [28], and Nader et al. [19]. Patients expressed a desire to receive clear information regarding their disease, treatment options, side effects, and prognosis. Inadequate information can lead to misunderstanding, confusion, or even false

hope among patients and their families. Despite the strengths of this study, several limitations should be considered when interpreting the findings. First, the study was conducted in a single hospital, which may limit the generalizability of the results to other healthcare settings and regions of Iraq. Second, the cross-sectional design prevents establishing causal relationships between patients' attitudes and healthcare providers' performance in breaking bad news. Third, data were collected using patients' self-reports, which may be subject to recall bias and social desirability bias. Fourth, healthcare providers' performance was assessed only from the patients' perspective and was not verified through direct observation or healthcare provider self-assessment. Future studies should include multiple healthcare settings, assess healthcare providers' perspectives in addition to patients' views, and use observational or longitudinal designs to better understand factors influencing the delivery of bad news. The findings of this study have important implications for clinical practice. Structured training programs based on established communication protocols, such as SPIKES, and adapted to the Iraqi cultural context may help improve healthcare providers' competence in breaking bad news. Given nurses' central role in patient communication, integrating patient-centered communication skills into undergraduate education and continuing professional development programs may enhance the quality of bad news delivery. In addition, involving family members in the disclosure process should be guided by patients' preferences rather than routine practice to support patient autonomy and culturally sensitive care. Overall, the findings indicate that healthcare providers' performance in breaking bad news was not fully aligned with patients' attitudes and preferences. Although no significant correlation was observed between the overall performance and attitude scores, important discrepancies were identified across several key aspects of bad news delivery. These findings underscore the need for culturally appropriate communication training to promote patient-centered care.

Conclusion

The findings indicate that patient-centered communication during the delivery of bad news remains suboptimal, with important discrepancies between patients' expectations and healthcare providers' practices. Addressing these gaps through culturally appropriate communication training and organizational support may facilitate more patient-centered care and improve the quality of healthcare communication.

Ethical Considerations

Ethics approval and consent to participate in the study were reviewed by the Research Ethics Committee at Kurdistan University of Medical Sciences ([IR.MUK.REC.1404.109](#)). All methods were carried out in accordance with the STROBE guidelines and the Declaration of Helsinki. Written informed consent was obtained from all the participants before enrollment in this study. For illiterate participants, verbal informed consent and a thumbprint were used. All authors have reviewed and approved the final manuscript and consent to its publication.

Acknowledgements

This article is the result of the dissertation for a master's degree in medical-surgical nursing and a research project approved by the research council of Kurdistan University of Medical Sciences. I thank and appreciate the respected officials of the studied hospitals, head nurses of wards, dear participants, and the research council.

Conflict of Interest

The authors declared no conflict of interest.

Funding

This research did not receive any financial support.

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All authors read and approved the final manuscript.

Artificial Intelligence Utilization

The authors utilized [ChatGPT (GPT-5.6 Luna)] to assist with English language editing. All authors retain full responsibility for the scientific content and final approval of the manuscript.

Data Availability Statement

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

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