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Cultural Differences in Perceived Appropriateness of Breaking Bad News to Patients: A Direct Comparison of Togo and France*

Diferencias Culturales en la Comunicación de Malas Noticias a los Pacientes: El Punto de Vista de los togoleses y de los franceses

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ABSTRACT
We examined cross-cultural differences in people's positions regarding the appropriateness of breaking of bad news to elderly patients. A total of 450 Togolese and French people who had in the past received bad medical news were presented with 72 vignettes depicting communication of bad news to elderly female patients and asked to indicate the appropriateness of physicians' conduct in each case. The vignettes comprised five pieces of information: (a) the severity of the disease, (b) the patient's wishes, (c) the level of social support during hospitalization, (d) the patient's psychological robustness, and (e) the physician's decision about communicating bad news. Through cluster analysis, six qualitatively different positions were found: (a) Always Tell the Truth to Patients, (b) Tell the Truth to Patients or their Relatives, (c) Depends on Patients' Wishes, (d) Tell the Truth to the Relatives, (e) Don't Tell the Truth to Patients, and (f) Undetermined. The French participants reported a stronger tendency to endorse the view that physicians should always tell the truth directly to the patient than the Togolese participants. In contrast, there was a stronger tendency among the Togolese participants to endorse the view that physicians should inform the patient's family first than among the French. These findings highlight the importance for physicians, at the time of delivering bad news, of considering patients' cultural values and of tailoring their disclosure approaches to match the diversity of patients' personal preferences.

Keywords
breaking bad news; cross-cultural comparison; France; Togo.

RESUMEN
Hemos examinado las posibles diferencias interculturales que existen en las perspectivas de las personas respeto a la comunicación de malas noticias a los pacientes ancianos. Setenta y dos viñetas describiendo una situación en la cual un médico comunica información a un paciente y/

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o a su familia fueron utilizadas. Las historias contenían cinco elementos de información: la gravedad de la enfermedad, los deseos del paciente, el nivel de soporte social que tiene el paciente, la condición psicológica del paciente, y la decisión del médico. La muestra era compuesta de 450 adultos que viven en el Togo o en Francia. Los participantes tenían que indicar su nivel de acuerdo con la decisión del médico en cada caso. A través de un análisis en clústeres, cinco posiciones diferentes fueron encontradas: (a) Siempre decir la verdad directamente al paciente, (b) Decir la verdad (que sea al paciente o a su familia), (c) Tener en cuenta los deseos del paciente a la hora de comunicar, (d) Decir la verdad a la familia, (e) Nunca decir la verdad al paciente. Algunos participantes expresaron una total indecisión. Los participantes franceses, con mucha más frecuencia que los participantes togoleses expresaron la idea que el medico tiene que decir la verdad directamente al paciente. Los participantes togoleses, al contrario, y con mucha más frecuencia que los participantes franceses, expresaron la idea que el medico no tiene que decir la verdad directamente al paciente (pero primero a su familia). Estos resultados muestran la importancia por un médico de considerar, a la hora de comunicar malas noticias, los valores culturales de los pacientes y de sus familias y de ajustar su comportamiento en función de la diversidad de los puntos de vista.

Palabras clave
comunicar malas noticias; diferencias interculturales; France; Togo.

Patient-clinician communication is a critical component of medical care. It has a significant impact on (a) patients' psychological adjustment to illness (Shofield et al., 2003); (b) their adherence to treatment (Watermeyer & Penn, 2012); (c) the outcome of the treatment itself (Franks, et al., 2005); (d) future patient-clinician relationships (Barnett, Fisher, Cooke, James, & Dale, 2007); and (e) patients' complaints to the justice system (Levinson, Roter, Mullooly, Dull, & Frankel, 1997). However, notifying patients that they have a poor prognosis is stressful, partly because patients have different desires and beliefs, and navigating these issues presents physicians with unique challenges. Guidelines on how to deliver bad news to adult patients, such as SPIKES and ABCDE (Kaplan, 2010; Fields & Johnson, 2012), tell physicians to be sensitive to individual patients' preferences, capacities, and needs.

Following these recommendations, many researchers have examined patients' personal preferences regarding the breaking of bad news. Igier, Muñoz-Sastre, Sorum and Mullet (2015) examined French people's views regarding the breaking of bad news to patients. They found four different positions: 28% of the participants preferred the full truth to be told to patients in all circumstances, 36% preferred the full truth to be told, but understood that the physician would inform the family first, 13% did not think that telling the full truth was good for any patient, and 23% preferred the full truth to be told in some cases and not in others, depending on the physician's perception of the situation.

Using a similar material, Kpanake, Sorum and Mullet (2016) examined Togolese's views. They found five positions: 2% of the participants preferred that the physician always tell the full truth to both the patient and her relatives, 8% preferred that truth be told depending on the physician's perception of the situation, 15% preferred that the physician tell the truth, but understood that in some cases, nondisclosure to the patient was not inappropriate, 33% preferred that the physician tell the full truth to the relatives but not as much information to the patient, and 42% preferred that the physician tell the full truth to the relatives only.

In the present study, we reanalyzed these already published data. As they were, as indicated earlier, obtained using a material that was similar, a single cluster analysis was performed on the whole set of data, which allowed (a) to more precisely determine the number of qualitatively different positions that exist in both samples and (b) to more accurately compare the percentages of participants holding each of these positions in each sample.

Method

Participants

The 450 participants were lay people living in France (Western Europe) or in Togo (Western Africa) and who had been told bad medical news

by a physician. They were recruited and tested in Toulouse for the French participants (N = 195), and in Lomé for the Togolese participants (N = 255). They were approached by research assistants when walking along the main sidewalks of their city. Their ages ranged from 18 to 68 years (M = 30, SD = 12.80). Additional demographic characteristics are shown in Table 1.

Material

The material consisted of 72 cards containing a story of a few lines, a question and a response scale. Five factors were manipulated:

1. The severity of the disease:
    a) severe but not lethal: the illness can be cured;
    b) severe, and lethal in one case out of three: a several-month period of hospitalization must be considered; or
    c) incurable, with a life expectancy of a few months: the patient must remain in the hospital.
2. The elderly patient's wishes regarding disclosure:
    a) insists on knowing the full truth; or
    b) wishes to know about her illness, but does not insist on knowing the full truth.
3. The level of social support during hospitalization:
    a) will have many visits from her relatives; or
    b) will be relatively alone.
4. The elderly patient's psychological robustness:
    a) psychologically robust; or
    b) psychologically frail
5. The physician's decision about communicating bad news:
    a) hid the truth from the elderly patient and her relatives;
    b) hid the truth from the elderly patient but told the full truth to her relatives;
    c) told the full truth to both the elderly patient and her relatives.

Other information was held constant: all the patients were identified as females and were about 70 years of age; they were cognitively intact. The following is an example of a story: "Mrs. [Patient name] is 70 years old. She suffers from a severe illness that is incurable given present knowledge. She will have to stay in the hospital. Her life expectancy is a few months. Mrs. [Patient name] is a person known to be psychologically robust. She is, however, isolated; her only family members live far away. She will hardly have any visitors. Mrs. [Patient name] wants to know what she is suffering from but does not insist on knowing the absolute truth. Dr. [Physician name] decided to hide the truth from Mrs. [Patient name] and her family. He told them that the illness was severe but that her life was not in danger."

Table 1

Demographic Characteristics of the Clusters

Characteristics	ATTP	TTP	DPW	TTR	DTT	Undetermined	Total
Country							
Togo	3 (1)^{a}	32 (13)^{a}	17 (7)^{a}	70 (27)^{a}	89 (35)^{a}	44 (17)^{a}	255
France	56 (29)^{a}	45 (23)^{a}	49 (25)^{a}	4 (2)^{a}	28 (14)^{a}	13 (7)^{a}	195
Gender							
Women	12 (8)^{a}	22 (14)	16 (10)	28 (18)	56 (36)^{a}	21 (14)	155
Men	47 (16)^{a}	55 (19)	50 (17)	46 (15)	61 (21)^{a}	36 (12)	295
Age							
18-20	1 (1)^{ab}	23 (16)	10 (7)^{ab}	46 (32)^{ab}	38 (26)	27 (18)^{a}	146
21-30	32 (21)^{a}	33 (22)	30 (20)^{a}	12 (8)^{a}	32 (21)	12 (8)^{a}	151
31+	26 (17)^{b}	21 (14)	26 (17)^{b}	16 (10)^{b}	47 (30)	18 (12)	153
Total	59	77	66	74	117	57	450

Note Figures in parentheses are percentages. Figures with the same exponent are significantly different, $p < .05$. ATTP = Always tell the truth to patients, TTP = Tell the truth, DPW = Depends on patient's wishes, TTR = Tell truth to relatives, and DTT = Don't tell the truth.

Under each story were a question and a response scale. The question was: "To what extent do you consider that the physician's behavior was, in this case, appropriate?" The response scale was an 11-point scale with a left-hand anchor of "Not at all" and a right-hand

anchor of "Completely." The procedure, inspired by Anderson (2016) has been fully described in Igier et al. (2015) and in Kpanake et al. (2016).

Results

A single cluster analysis was performed on the whole sample (Togo + France) using the K-means method advocated by Hofmans and Mullet (2013). A six-cluster solution was retained based on the technique advocated by Schepers and Hofmans (2009).

The patterns of data that correspond to each cluster are shown in Figure 1. In each panel, judged appropriateness of the physicians' behavior is on the vertical axis. The three possible physician behaviors are on the horizontal axis. The two curves express the patients' wishes. Finally, each panel corresponds to one cluster of participants. The effect of the level of social support during hospitalization, the effect of the severity of the disease and the effect of the patient's psychological robustness were not shown because their impact was generally weak. The distribution of participants in each of the five clusters is shown in Table 1. Separate analyses of variance (ANOVAs) were conducted on the data of each cluster, using a Severity × Wishes × Support × Psychological robustness × Physician's decision, 3 × 2 × 2 × 2 × 3 design. The detailed results of these ANOVAs can be obtained from the corresponding author.

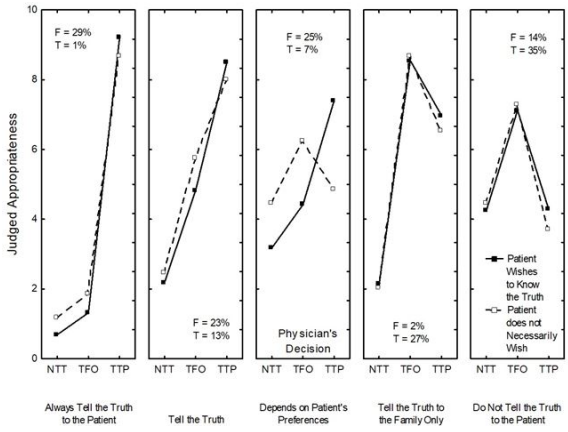
The first cluster (N = 59, 13% of the sample), was the cluster of people for whom telling the full truth to the patient was the only appropriate decision (M = 9.01). It was called *Always Tell the Full Truth to the Patient*. Hiding the truth from the patient (M = 2.05), or not telling the full truth to anybody (M = 0.66) was considered as clearly inappropriate, irrespective of the other circumstances (see Figure 1, left panel). As shown in Table 1, French patients (29%) were much more likely to belong to this cluster than Togolese patients (1%).

The second cluster (N = 76, 17%) was called *Tell the Truth to the Patient or Relatives* because the only appropriate decision for these participants was to tell the truth to the patient (M = 8.38) or her relatives (M = 5.69). This position was, therefore, more nuanced than the previous cluster's one: Ratings were still high when the physicians tell the truth to the patient's relatives only. French patients (23%) were more likely to belong to this cluster than Togolese patients (13%).

The third cluster (N = 66, 15%) was called *Depends on Patient's Wishes* because the patient's wishes were the factor that has a major impact on appropriateness judgments. When the patient wished to know the full truth, telling it was considered more appropriate (M = 6.65) than the other options (M = 5.30 and 3.70, respectively). When the patient did not insist on knowing the full truth, not telling it was considered more appropriate (M = 5.77) than the other options (M = 5.08 and 3.30, respectively). Overall, however, telling the full truth was considered as more appropriate (M = 5.98) than the other two options (M = 5.60 and 4.47, respectively). French participants (25%) were more likely to belong to this cluster than Togolese participants (7%).

The fourth cluster (N = 73, 16% of the sample) was a cluster of people for whom hiding the truth from the patient but telling the full truth to her relatives was, in most cases, considered as the most appropriate option (M = 8.71). Telling the full truth directly to the patient was considered as less appropriate (M = 2.0), although hiding the truth was considered totally inappropriate (M = 2.26). This cluster was called *Tell the Truth to the Relatives*. Togolese participants (27%) were more likely to belong to this cluster than French participants (2%).

Figure 1
Patterns of results corresponding to five of the six clusters: Always Tell the Full Truth to Patents, Tell the Truth to Patients or Relatives, Depends on Patient's Wishes, Tell the Truth to Relatives and Do not Tell the Truth to the Patient



In each panel, (a) the judged appropriateness of the physician's behavior is on the y-axis; (b) the three levels of the physician's behavior are on the x-axis (DTT = Did not tell the truth to anybody, TTR = Told the truth to the relatives, and TTP = Told the truth to the patient); and (c) the two curves correspond to the two levels of the patient's wishes.

The fifth cluster (N = 116, 26%) was called *Don't Tell the Truth to the Patient* because it brings together participants who considered that, hiding the truth from the patient but telling the full truth to her relatives was the most appropriate option in all cases (M = 7.26). Telling the full truth to the patient or hiding the truth from her family was considered as much less appropriate (M = 4.36 and 3.45, respectively). Togolese participants (35%) were more likely to belong to this cluster than French participants (14%).

The sixth cluster (N = 60, 13%) was called *Undetermined* because ratings were always close to the center of the response scale (M = 5.09). Ratings were slightly higher when the physician told the full truth to both the patient and her relatives (M = 6.65) than when he hides it (M = 3.70). Togolese participants (17%) were significantly more likely to belong to this cluster than French participants (7%).

Discussion

As expected, putting together and reanalyzing the data gathered by Igier et al. (2015) and by Kpanake et al. (2016) allowed a more fine-grained analysis of people's positions regarding the breaking of bad news to patients. Six clusters were found that corresponded to five interpretable positions and, for a small group of participants, to the expression of indetermination, whereas only four clusters had been identified by Igier et al. (2015) and only five clusters by Kpanake et al. (2016). Overall, (a) the French participants, more often than the Togolese participants endorsed the view that physicians should tell the truth directly to the patient, particularly when he or she wishes to receive this information, and (b) the Togolese participants, more often than the French participants, endorsed the view that physicians should inform the patient's family first.

These findings were consistent with previous empirical studies in sub-Saharan African countries that suggested that respect for individual autonomy in health care is not a strongly endorsed value among African people (Kpanake, Dassa, Sorum, & Mullet, 2014; Solum, Maluwa, & Severinsson, 2012; see also Kpanake, 2018). The salience of individual autonomy and self-determination in Western Europe cultural context may explain the French sensitivity to patients' autonomy in health communication. In contrast, the Togolese preference for family involvement in the breaking of bad news reflects cultural values promoted in Africa, such as interdependence and communalities. These African cultural values may have produced sociocultural norms that do not promote patients' autonomy regarding the breaking of bad news to patients.

Furthermore, in many African cultures, the break of bad news such as grave illness should be performed by a culturally designated appropriate person, appropriately, at an appropriate time and place (Beyene, 1992). In the Ethiopian cultural context, for instance, "the disclosure of bad news is staged, and close friends and family members prepare persons to face disturbing news

by leading them to it gradually. The situation is discussed among friends and relatives to decide the appropriate time and the least frightening way of breaking the news" (Beyene, 1992, p. 330). An additional explanation is that whereas in medically developed countries such as France disclosure of bad news may guide patients throughout numerous treatment options, in the Togolese context such disclosure may undermine patients' hope since they are aware of the lack therapeutic options.

Implications

The diversity of positions among Togolese and French peoples, regarding the breaking of bad news, implies that health professionals working with those clients may expect to encounter, in their daily practice, patients and their relatives holding the diverse positions found by this study. Thus, the cross-cultural consistency of individual variations in preferences for physicians' delivery of bad news strengthens the importance for physicians, at the time of delivering bad news, to tailor their interventions to each patient. This happens in Togo as well as in France, instead of using a "one size fits all" approach or an alternative "two sizes fit all, one for Africans and one for Europeans".

The findings of the current study also highlight the importance for health professionals to consider cross-cultural differences when exploring breaking bad news to patients. It provides preliminary evidence to suggest that people in Togo, and probably in other African countries, disagree with the Western construct of respect for individual patient autonomy when breaking bad news to patients. In fact, it was clear that the concept of the patient as an independent entity whose interests might differ from those of family members and health professionals in the community lacks cultural legitimacy in Togo. While the application of "universal" ethics guidelines in health communication may somehow contribute to a better healthcare on the African continent, respect for patient's values and preferences are as important as evidence-based medicine.

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Notes

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