Health, 2026, 18(3), 249-263
https://www.scirp.org/journal/health
ISSN Online: 1949-5005
ISSN Print: 1949-4998

Breaking Bad News in Nigerian Clinical Settings: Assessment of Practices, Competence, and Associated Factors among Physicians

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How to cite this paper: Ejikem, P.E., Ekeleme, N.C., Ejikem, M.U., Adelotan, A.T. and Amatameso, B.E. (2026) Breaking Bad News in Nigerian Clinical Settings: Assessment of Practices, Competence, and Associated Factors among Physicians. *Health*, **18**, 249-263.
https://doi.org/10.4236/health.2026.183017

Received: December 1, 2025
Accepted: March 16, 2026
Published: March 19, 2026

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Abstract

Background: Breaking bad news is a demanding part of clinical work, and how it is delivered can shape patient trust, cooperation, and overall experience. In many low- and middle-income countries, including Nigeria, physicians often have limited formal preparation for this task. This study explored how Nigerian physicians currently deliver bad news, how well they follow the SPIKES protocol, and the barriers they face. **Methods:** A descriptive cross-sectional survey was carried out among physicians attending the 2022 Nigerian Medical Association Annual Conference. Using a structured questionnaire, the study gathered information on demographic characteristics, breaking-bad-news practices, adherence to SPIKES, and perceived challenges. Data from 183 respondents were analyzed using SPSS, with descriptive and chi-square statistics applied. **Results:** Most participants were male consultants working in tertiary hospitals. Notably, 38.8% had received no formal training in breaking bad news, a significant gap for such a core clinical skill; the remaining 61.2% had received some form of prior training. Nearly all had communicated bad news during their careers, yet 41% recalled negative outcomes linked to poor delivery. Although there was strong support for formal training and willingness to attend future sessions, only about 60% reported consistent use of the SPIKES protocol. Key barriers included insufficient training, lack of time, emotional strain, language difficulties, and long work hours. Competence was not significantly associated with professional experience or cadre. **Conclusion:** The study underscores an ongoing need to embed structured communication training, including SPIKES, into medical education and continuous professional development. The persistent gap in formal training—with nearly four in ten physicians

lacking it—highlights that progress remains incomplete. Improving these skills could promote more patient-centered care and better emotional outcomes in clinical practice.

Keywords

Breaking Bad News, SPIKES Protocol, Physician Competence, Communication Skills, Medical Ethics, Nigeria, Patient Care

1. Introduction

Breaking bad news remains an essential and unavoidable part of clinical work. It requires more than clinical accuracy, it demands nuanced communication, cultural awareness, and sound ethical judgment. The phrase "breaking bad news" typically refers to delivering information that significantly and negatively changes a person's expectations for their future, such as the diagnosis of a life-limiting disease, a poor prognosis, a major treatment failure, or a patient's death. How clinicians communicate this information shapes how patients and families process distress, adjust psychologically, decide on treatment options, and trust their care providers. Frameworks such as the SPIKES protocol were created to guide clinicians through preparing the conversation, delivering information clearly, responding to emotions, and planning the next steps, supporting a more patient-centered and ethically sound disclosure process [1].

Despite the existence of such structured communication models, actual practice varies widely. High-income countries have invested heavily in communication skills training across medical education and continuing professional development, yet clinicians there still report discomfort and inconsistent protocol use. In many low- and middle-income countries (LMICs), especially across Sub-Saharan Africa, the challenges are amplified. Training opportunities are fewer, patient loads are high, psychosocial and multidisciplinary support systems are limited, and clinicians often must manage complex family expectations during disclosure [1].

Nigeria reflects many of these wider challenges, along with unique cultural influences. Earlier studies from southwestern Nigeria revealed a noticeable gap between perceived and actual competence: while many clinicians believed they were proficient in breaking bad news, only a minority had formal training, and structured protocols were seldom used. Many disclosures were improvised or delegated, sometimes to relatives rather than patients. This highlighted a kind of "unconscious incompetence", raising ethical concerns around autonomy, consent, and emotional harm to patients and families [2].

More recent studies have provided updated insights into Nigerian practice. A 2025 nationwide cross-sectional study found that adherence to the SPIKES protocol is highly variable. Some clinicians reported using SPIKES explicitly, while others described partial or modified approaches shaped by local realities, such as pri-

oritizing family involvement, providing selective information, or focusing on immediate management rather than long-term psychosocial needs. These findings show that while awareness of structured communication frameworks is increasing, full adherence remains inconsistent, and local adaptations (some helpful, others potentially problematic) are widespread [3].

Several interconnected factors appear to shape clinicians' competence in breaking bad news in Nigeria. These include prior training (undergraduate, residency, and in-service), clinical experience and specialty, workload pressure, limited privacy for consultations, and concerns about medico-legal consequences. Cultural expectations also play a powerful role: in many Nigerian communities, families expect to receive serious medical information before the patient or may shield the patient from unpleasant details. Language differences and the absence of professional interpreters further complicate communication. Doctors' fear of delivering bad news has been associated with concerns about being blamed, provoking strong reactions, displaying emotion, lacking all the answers, confronting unfamiliar or untrained situations, and facing their own anxieties about illness and death [4]. In short, competence is shaped not only by individual skill but by institutional and societal forces.

These findings highlight the need for a systematic assessment of current practice in Nigeria, focusing on physicians' knowledge of disclosure protocols, their adherence to evidence-based approaches, and the factors that facilitate or hinder good practice. Such an assessment offers the possibility of shaping more relevant training, institutional policies, and culturally attuned communication tools grounded in protocols like SPIKES [3]. Improving the communication of bad news has both clinical and ethical implications: it can strengthen patient autonomy, reduce unnecessary distress, improve adherence and shared decision-making, and build trust between healthcare providers and communities.

Given the gaps noted in existing Nigerian and regional studies, the present research aims to provide nationally relevant evidence on current practices, competence levels, and determinants of breaking bad news among Nigerian physicians. The findings can guide targeted interventions, from curricular reforms and residency training to hospital-level protocols, mentorship systems, and institutional safeguards, tailored to Nigeria's cultural and resource settings while still aligned with global best practices.

2. Research Methodology

2.1. Study Design

A descriptive cross-sectional study.

2.2. Study Setting

The study was conducted during the annual Nigerian Medical Association (NMA) Conference, held from 15th to 22nd May 2022, which represents the largest congregation of physicians nationwide.

2.3. Study Population

Registered physicians practicing in Nigeria who attended the 2022 NMA conference.

2.4. Inclusion and Exclusion Criteria

Licensed Nigerian physicians attending the conference who gave their consent to participate were included, while non-physician health workers and physicians who declined consent or did not complete the questionnaire were excluded.

2.5. Sample Size and Sampling Method

All consenting physicians attending the conference were approached. A convenience sampling strategy was used, capitalizing on the diversity of specialties and regions represented at the event.

2.6. Data Collection Tool

A structured, self-administered questionnaire adapted from previously validated studies [2] [5] [6] was used. The instrument comprised four parts: socio-demographic information; current practices in breaking bad news; adherence to the SPIKES protocol; and perceived barriers and challenges.

2.7. Data Collection Procedure

Questionnaires were distributed to consenting participants at registration booths, while seated during breaks and during plenary sessions. Participation was entirely voluntary and anonymous.

2.8. Data Analysis

Data were coded and analyzed using SPSS v.25. Descriptive statistics (frequency, mean, percentages) were used to summarize the data. Associations between training exposure and competence were tested using chi-square analysis. For the purposes of analysis, self-reported competence was dichotomized into two categories based on responses to item 9 of the questionnaire ("Ability to break bad news"): respondents who selected "Very good" or "Good" were classified as having "Good competence", while those who selected "Fair", "Poor", or "Very poor" were classified as having "Poor competence". This cut-off was pre-specified to distinguish those reporting above-average self-assessed skill from those reporting average or below-average skill.

2.9. Ethical Considerations

Ethical clearance was obtained from the Abia State University Teaching Hospital Institutional Review Board (ABSUTH/MAC/117/VOL.11/64). Participation was voluntary, informed consent was obtained, and confidentiality was ensured by de-identifying responses.

3. Results

This study involved 183 physicians whose socio-demographic characteristics are presented in Table 1. The majority of respondents (43.2%) were aged 41 - 50 years, while 55.7% were male. More than half (52.5%) had been in practice for 11 - 20 years, and nearly half (44.8%) were consultants. The most common specialty was Family Medicine/General Practice (25.6%). A substantial proportion (72.1%) worked at tertiary healthcare facilities, and half (50.8%) had practiced between 11 - 20 years.

Table 1. Socio-demographic characteristics of the respondents (N = 183).

S/N	Variables	Frequency	Percentage (%)
1	Age		
	Less than 30 years	8	4.4
	31 - 40 years	56	30.6
	41 - 50 years	79	43.2
	51 - 60 years	26	14.2
	More than 60 years	14	7.6
2	Gender		
	Male	102	55.7
	Female	81	44.3
3	Years of practice		
	0 - 10 years	29	15.8
	11 - 20 years	96	52.5
	21 - 30 years	41	22.4
	More than 30 years	17	9.3
4	Professional cadre		
	Medical officer	41	22.4
	Resident	60	32.8
	Consultant	82	44.8
5	Medical specialty		
	Family medicine/general practice	47	25.6
	Anesthesiology	9	4.8
	Psychiatry	5	2.6
	Obstetrics and gynecology	28	15.3
	Surgery	14	7.6
	Internal medicine	17	9.2
	Pediatrics	18	9.8
	Emergency medicine	2	1.0
	Dentistry/dental surgery	10	5.4

Continued

	Radiology	6	3.2
	Pathology	3	1.6
	Others	24	13.1
	None	4	2.1
6	Level of care		
	Primary	13	7.1
	Secondary	38	20.8
	Tertiary	132	72.1
7	Duration of practice		
	Less than 10 years	32	17.5
	11 - 20 years	93	50.8
	21 - 30 years	41	22.4
	More than 30 years	17	9.3

Regarding the practice of breaking bad news (Table 2), 61.2% of physicians had received prior training, while an overwhelming majority (96.2%) had previously broken bad news to patients or their families. Although 41.0% had experienced challenges resulting from improper communication, 97.3% recognized the need for further skill development, and 96.2% expressed willingness to attend future training sessions. Two-thirds (67.8%) preferred discussing bad news with both patients and their families, and 58.5% usually obtained patient consent before sharing information with family members. When identifying the most difficult aspect of breaking bad news, 33.9% cited "being honest without taking away hope", while 33.3% found "managing the patient's emotions" most challenging. In terms of competence, 48.6% rated themselves as having good ability, and 13.1% rated themselves as very good.

Table 2. Practices of breaking bad news (N = 183).

S/N	Variable	Frequency	Percentage (%)
1	Ever received any education/training for breaking bad news?		
	Yes	112	61.2
	No	71	38.8
2	Ever broken bad news to patients or patients' family		
	Yes	176	96.2
	No	7	3.8
3	Had bad experiences due to improperly breaking bad news?		

Continued

	Yes	75	41.0
	No	108	59.0
4	Adequate skill development training is needed in breaking bad news		
	Yes	178	97.3
	No	5	2.7
5	Willing to attend training regarding breaking bad news in the future		
	Yes	176	96.2
	No	7	3.8
6	Prefer to talk with a patient or the family members when breaking bad news		
	Patient	39	21.3
	Family member	20	10.9
	Both	124	67.8
7	Obtained consent from patients before breaking bad news to the patients' family		
	Never	26	14.2
	Usually	107	58.5
	Sometimes	50	27.3
8	Most difficult part of discussing bad news		
	Being honest but not taking away hope	62	33.9
	Dealing with the patient's emotions (e.g., crying, anger, etc.)	61	33.3
	Discussing end-of-life issues	43	23.5
	Involving family and friends of the patient	6	3.3
	Telling patients about recurrence	11	6.0
9	Ability to break bad news		
	Very good	24	13.1
	Good	87	47.5
	Fair	69	37.7
	Poor	1	0.5
	Very poor	2	1.1

Based on the categorization of respondents who selected "Very good" or "Good" as having "Good competence" (N = 111), and those who selected "Fair", "Poor", or "Very poor" as having "Poor competence" (N = 72), Figure 1 further illustrates that 60.7% of respondents self reported good competence in breaking bad news, while 39.3% were self-reported having poor competence.

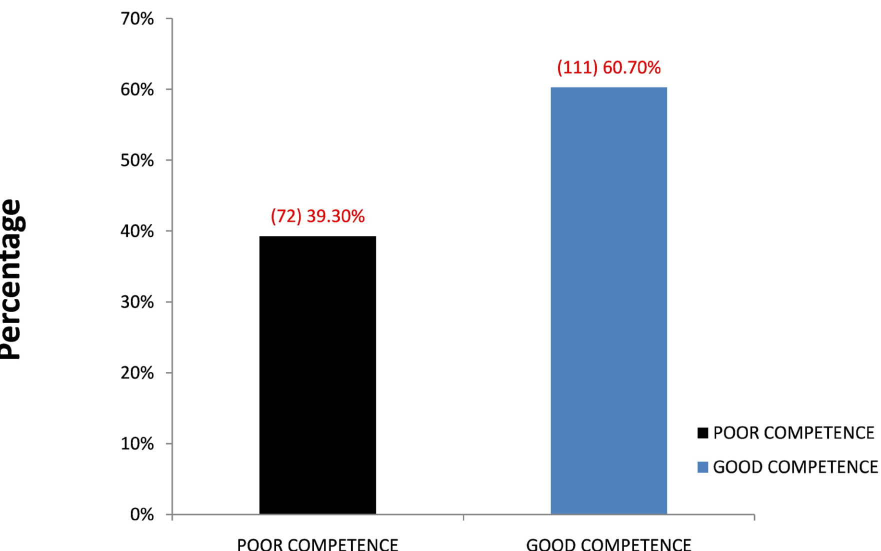

Figure 1. Level of self-reported competence in delivering bad news.

The adherence to the SPIKES protocol (**Table 3**) demonstrated generally high compliance. Most respondents reported "usually" following the recommended steps: setting up a private and comfortable environment (69.9%), assessing patients' perceptions (63.4%), obtaining the patient's invitation to discuss their condition (59.0%), providing clear knowledge and information (66.1%), responding empathetically to emotions (64.5%), and explaining future treatment or prognosis (72.7%).

Table 3. Adherence to the SPIKES protocol in breaking bad news to patients (N = 183).

S/N	Statements	Never	Usually	Sometimes
1	Set up or plan the interview for the patient to feel comfortable and maintain privacy	15 (8.2)	128 (69.9)	40 (21.9)
2	Assess the patient's perception (what he/she already knows) about the condition	14 (7.7)	116 (63.4)	53 (29.0)
3	Obtain the patient's invitation (ask him/her what they want to know)	23 (12.6)	108 (59.0)	52 (29.5)
4	Give knowledge and information to the patient about his/her condition	8 (4.4)	121 (66.1)	54 (29.5)
5	Assess the patient's emotions with emphatic responses	9 (4.9)	118 (64.5)	56 (30.6)
6	Explain future strategy, including treatment options and prognosis	9 (4.9)	133 (72.7)	41 (22.4)

Concerning barriers to breaking bad news (**Table 4**), the most strongly agreed obstacle was lack of formal training (42.1%). Other notable barriers included time constraints (37.7%), long working hours and exhaustion (35.0%), language

barriers (33.3%), and fear of triggering strong emotional reactions (37.7%). Additional concerns were fear of the patient's reaction (39.3%) and apprehension about being blamed or perceived as incompetent (27.9% and 26.2%, respectively).

Table 4. Barriers to breaking bad news (N = 183).

S/N	Statement	SD	D	N	A	SA
1	Lack of formal training	11 (6.0)	16 (8.7)	19 (10.4)	60 (32.8)	77 (42.1)
2	Time constraints	17 (9.3)	33 (18.0)	32 (17.5)	69 (37.7)	32 (17.5)
3	Language barrier	14 (7.7)	33 (18.0)	34 (18.6)	61 (33.3)	41 (22.4)
4	Long work hours/ exhaustion	14 (7.7)	36 (19.7)	27 (14.8)	64 (35.0)	42 (23.0)
5	Fear of being blamed	18 (9.8)	45 (24.6)	46 (25.1)	51 (27.9)	23 (12.6)
6	Fear of being seen as incompetent	27 (14.8)	48 (26.2)	39 (21.3)	46 (25.1)	23 (12.6)
7	Fear of expressing emotion or unleashing a reaction	19 (10.4)	29 (15.8)	41 (22.4)	69 (37.7)	25 (13.7)
8	Fear of the patient's reaction	14 (7.7)	33 (18.0)	34 (18.6)	72 (39.3)	30 (16.4)
9	Fear of losing patient to follow up	27 (14.8)	44 (24.0)	38 (20.8)	47 (25.7)	27 (14.8)

Key: SD = Strongly Disagree; D = Disagree; N = Neutral; A = Agree; SA = Strongly Agree.

The association between physicians' training background and their self-reported competence in delivering bad news is shown in Table 5. Although physicians with 21 - 30 years of practice and those in Psychiatry, Anesthesiology, and Surgery specialties showed higher proportions of good competence, none of the relationships between competence and predictors such as years of practice, cadre, specialty, level of care, or duration of practice were statistically significant ($p > 0.05$).

Table 5. Association between the physicians' training background and their self-reported competence in delivering bad news (N = 183).

Variables	Good Competence (N = 111)	Poor Competence (N = 72)	Statistics (χ^2, p)
Years of practice			
Less than 10 years	15 (51.7)	14 (48.3)	χ^2= 5.553*; p = 0.135
11 - 20 years	60 (62.5)	36 (37.5)	
21 - 30 years	29 (70.7)	12 (29.3)	
More than 30 years	7 (41.2)	10 (58.8)	

Continued

Professional cadre			
Medical officer	20 (48.8)	21 (51.2)	χ^2 = 3.159#; p = 0.206
Resident	39 (65.0)	21 (35.0)	
Consultant	52 (63.4)	30 (36.6)	
Medical specialty			
Family medicine/general practice	29 (61.7)	18 (38.3)	χ^2 = 20.823#; p = 0.233
Anesthesiology	8 (88.9)	1 (11.1)	
Psychiatry	5 (100.0)	0 (0.0)	
Obstetrics and gynecology	13 (46.4)	15 (53.6)	
Surgery	10 (71.4)	4 (28.6)	
Internal medicine	8 (47.1)	9 (52.9)	
Pediatrics	12 (66.7)	6 (33.3)	
Emergency medicine	1 (50.0)	1 (50.0)	
Dentistry/dental surgery	7 (70.0)	3 (30.0)	
Radiology	3 (50.0)	3 (50.0)	
Pathology	1 (33.3)	2 (66.7)	
Others	12 (60.0)	8 (40.0)	
None	2 (50.0)	2 (50.0)	
Level of care			
Primary	5 (38.5)	8 (61.5)	χ^2 = 2.957*; p = 0.228
Secondary	23 (60.5)	15 (39.5)	
Tertiary	83 (62.9)	49 (37.1)	
Duration of practice			
Less than 10 years	16 (50.0)	16 (50.0)	χ^2 = 6.272*; p = 0.099
11 - 20 years	59 (63.4)	34 (36.6)	
21 - 30 years	29 (70.7)	12 (29.3)	
More than 30 years	7 (41.2)	10 (58.8)	

Key: * = Pearson's chi-square; # = Likelihood ratio.

4. Discussion

This study explored how Nigerian physicians deliver bad news, how competent they feel, their adherence to the SPIKES protocol, and the barriers they face. The demographic profile, largely physicians aged 41 - 50, mostly male, many with more than a decade of experience, and a substantial number working in tertiary hospitals, provides an important backdrop. These characteristics help contextualize the high exposure to difficult clinical conversations, the confidence expressed by many respondents, and the competing pressures that shape communication choices. Similar trends have been documented in earlier Nigerian studies, where older and sen-

ior clinicians in tertiary hospitals often shoulder the responsibility for breaking bad news [2].

The finding that 61.2% of respondents reported receiving some training in breaking bad news represents a relative improvement over earlier Nigerian research, in which only a small fraction of clinicians had formal training. However, it is important not to overstate this progress: 38.8% of physicians in this study—nearly two in five—still reported having received no formal training in this core clinical skill. This persistent gap is concerning and underscores that training remains far from universal. In 2013, Adebayo and colleagues described widespread "unconscious incompetence", where clinicians reported confidence despite limited formal education in communication [2]. The present data suggest this problem has not been fully resolved. The quality and consistency of training still vary widely, and knowing about techniques of breaking bad news does not automatically translate into mastery.

Nearly all physicians in this study had delivered bad news in practice. This mirrors international evidence showing that breaking bad news is universal across clinical environments. What differs is the degree of preparedness and the support systems available [7]. The gap between perceived competence and actual SPIKES adherence is telling. Although many physicians feel confident in delivering bad news, a 2024 cross-sectional study of 245 Nigerian doctors found that only 60.3% demonstrated full protocol adherence, with variability driven by training, specialty, and facility type [3]. In our study, the most consistently followed step was that related to explaining future strategy and treatment options (72% "usually" carried out this step), followed by setting up the interview to accommodate patient's privacy and comfort. Like a study carried out in southwestern Nigeria, more relational steps, such as assessing the patient's understanding or exploring how much they wished to know, were less reliably performed [3]. This also mirrors Ethiopian data, where adherence to the "Knowledge" and "Emotion" steps was markedly lower than to structural steps like "Setting" [8].

Cultural context shapes these patterns further. In Nigeria, involving the family in disclosure is not simply a preference but a reflection of communal values, where the family often functions as the primary decision-making unit [2]. This diverges from the individual autonomy model on which SPIKES was built, prompting many clinicians to adapt the protocol to local realities rather than apply it wholesale [9].

Barriers identified by respondents, including insufficient training, time constraints, emotional pressures, language difficulties, and concerns about patient reactions, echo both Nigerian and LMIC literature. A cross-sectional study conducted in southwestern Nigeria found that the majority of health professionals had little or no knowledge of established protocols for breaking bad news, and despite rating their own competence highly, were effectively "unconsciously incompetent"—a pattern attributed largely to inadequate formal training [2]. This finding is consistent with a multi-country survey of oncology providers in Nigeria, Kenya, Ghana, and Rwanda, which revealed that only 20% of physicians had re-

ceived formal communication skills training, and only 20% - 25% reported having a consistent strategy for breaking bad news to cancer patients. Cultural factors compound these challenges, as physicians in African settings must navigate family wishes around disclosure, disease-related stigma, and the communal norms that often favor delivering grave diagnoses to relatives rather than patients directly [10].

Fear of causing psychological harm, uncertainty about the patient's reaction, and the desire not to extinguish hope have also been identified as significant attitudinal barriers [11]. Additionally, health systems constraints endemic to LMICs—including inadequate privacy, overwhelming patient loads, and the absence of institutional policies—further impede effective disclosure [12].

Taken together, these findings underscore the need for contextually adapted communication skills training embedded within medical education across African and LMIC settings.

An important finding of this study is that self-reported competence was not significantly associated with years of practice, professional cadre, medical specialty, level of care, or duration of practice (all $p > 0.05$). This result carries meaningful implications. First, it challenges the assumption that more experienced or senior physicians are inherently more proficient at delivering bad news. That consultants and long-serving physicians do not outperform their junior colleagues on self-reported competence suggests that clinical experience alone does not compensate for lack of structured training in communication skills. Second, the lack of specialty-based differences suggests that poor preparedness is a profession-wide problem, not confined to particular clinical areas—even though one might expect psychiatrists or palliative care physicians to have greater exposure. These findings reinforce the argument for universal, standardized communication training across all cadres and specialties, rather than assuming competence develops naturally through experience. They also point to a potential ceiling effect: if physicians across the board feel only moderately competent, targeted training could yield broad improvements regardless of career stage.

5. Limitations

Several limitations should be considered when interpreting these findings. First, the study used a convenience sample of physicians attending the 2022 NMA Annual Conference, which may not be representative of all practicing physicians in Nigeria. Physicians who attend a national professional conference may be more engaged, better resourced, and more aware of evidence-based practice than the broader physician workforce. This could lead to an overestimation of training exposure and self-reported competence across the country. Second, the cross-sectional design precludes causal inference; it is not possible to determine whether training leads to improved competence or whether more confident physicians seek out training. Third, self-reported competence, while a valuable indicator of perceived skill and confidence, may not accurately reflect actual clinical perfor-

mance. Social desirability bias may have led some respondents to rate themselves more favorably than their practice warrants. Fourth, the study was conducted at a single time point at one national event, limiting temporal and geographic generalizability. Future studies should use multi-site sampling strategies, objective measures of communication skill, and longitudinal designs to build on these findings.

6. Conclusions

This study documents some progress in training exposure and self-reported competence compared with older Nigerian data, while exposing persistent and significant gaps in consistent SPIKES adherence and systemic barriers that blunt communication quality. The fact that nearly 40% of physicians still lack formal training on breaking bad news—a fundamental clinical skill—demands urgent attention. The findings are broadly consonant with contemporary Nigerian and international studies: partial training may improve confidence, but meaningful, sustained improvement in how bad news is delivered will require standardized curricula embedded across undergraduate and postgraduate medical education, institutional supports such as mentorship and protected consultation time, and culturally informed practice guidelines. Without these systemic changes, gaps in competence will persist regardless of individual motivation.

What is already known on this topic

1) Many clinicians worldwide struggle with breaking bad news, and despite the availability of structured communication models such as SPIKES, adherence is often inconsistent, especially in settings with limited formal training.

2) Evidence from several Nigerian and Sub-Saharan African studies shows substantial gaps between clinicians' self-perceived competence and their actual use of structured disclosure protocols, with many relying on informal, ad hoc approaches.

3) Cultural expectations, heavy workloads, and systemic constraints, such as limited training opportunities, language barriers, and strong family involvement, play a major role in shaping how physicians deliver bad news in Nigeria and similar low- and middle-income contexts.

What this study adds

1) Despite relative improvements over historical data, nearly 40% of Nigerian physicians still lack formal breaking-bad-news training, demonstrating that the problem of inadequate preparation remains widespread and has not been resolved by existing education systems.

2) Self-reported competence was not significantly associated with years of practice, cadre, or specialty—challenging the assumption that experience substitutes for structured training and supporting the case for universal, profession-wide communication skills education.

3) Convenience sampling from a national conference may overestimate training exposure nationally; community and rural physicians who lack access to such events are likely underrepresented, suggesting the actual gap in training across Ni-

geria may be wider than this study captures.

Authors' Contributions

Patricia Eke Ejikem: Title, introduction/background, design of questionnaire. Ngozichukwu Cynthia Ekeleme: Methodology, discussion of results. Maif Uchenna Ejikem: Analysis of data, summary of results. Anuoluwapo Tosin Adelotan: Data collection. Blessing Emmanuel Amatameso: Data collection.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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