Letter to Editor

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A Commentary on Emergency Department Staff Performance versus Patient Preferences in Breaking Bad News

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Dear Editor

I commend the authors for their insightful manuscript, "Comparing the Performance of Emergency Department Personnel and Patients' Preferences in Breaking Bad News" [1]. This study examined a sensitive yet critical aspect of emergency care—delivering bad news effectively in high-stress environments. The findings highlighted a notable discrepancy between emergency department (ED) personnel's communication practices and patients' expectations, underscoring the need for structured training and improved communication protocols in emergency medicine.

Strengths of the Study

The study addresses a critical and under-explored aspect of healthcare delivery— breaking bad news (BBN) in EDs—where time constraints and emotional stakes are high. This focus is particularly relevant for enhancing patient-centered care.

1) ***Empirical Comparison of Staff Performance and Patient Preferences***: The study effectively contrasted healthcare providers' approaches with patient expectations, identifying key areas for improvement in BBN.

2) ***Robust Data Collection Tools:*** The use of a researcher-made questionnaire (with binary scoring) alongside a validated standard questionnaire [2] enhanced the study's ability to capture both objective performance and subjective patient attitudes. The reported validity (content validity index [CVI] and content validity ratio [CVR]) and reliability (Cronbach's alpha) further supported the instruments' credibility.

3) ***Statistical Rigor:*** The study employed appropriate statistical methods (Spearman correlation, Wilcoxon signed-rank test) to account for non-normal data distribution, and the significance threshold (p<0.05) was clearly defined.

Areas for Further Consideration

1) ***Limited Generalizability:*** The study was conducted using quota sampling in only two hospitals (Kowsar and Tohid) in Sanandaj, Iran, which restricted the generalizability of findings to other regions, cultures, or healthcare systems with different ED dynamics, staffing patterns, or patient demographics. While the authors acknowledged this limitation, further discussion of its implications would have been beneficial.

2) ***Exploring the Role of Bad-News Deliverers:*** The study noted that 69.6% of bad news was delivered

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by nurses, compared to 30.4% by physicians, which was in contrast with patient preferences. Similarly, Pourramzani *et al.,* found that 82.3% of patients preferred to receive bad news from the head of the medical team [3]. Another study also indicated that nurses might feel uncertain about delivering bad news [4], a concern that was not fully addressed in the present study. While the shift in responsibility could be attributed to workload distribution and an interdisciplinary approach, further explorations, such as Are nurses trained for this role?, How does this shift impact communication?, are required. Besides, investigating physicians' limited involvement and potential collaborative improvements could enhance bad-news delivery in emergency settings.

3) ***Sampling Bias:*** Quota sampling, although practical, was a non-probabilistic method and could introduce bias by not ensuring equal selection probability [5]. In the present study, the inclusion of 135 patients based on criteria, such as bed numbers, full consciousness, and stable hemodynamics, likely excluded critically ill patients, where BBN could be more complex or urgent. This method tended to overrepresent patients with less severe conditions, limiting the generalizability of the findings to all patient scenarios, particularly in emergency settings.

4) ***Subjectivity in Performance Assessment:*** The researcher-made questionnaire assessed personnel performance via patient perceptions (e.g., "Did the deliverer make eye contact?"). Recall bias or emotional distress during BBN could distort responses [6], undermining the objectivity of the performance score (6.08±4.22). No triangulation, such as using personnel self-reports or observer data, was attempted.

5) ***Ambiguity in "Bad News" Definition:*** While the study defined bad news as causing "hopelessness or restricted decision-making", specific scenarios (e.g., diagnosis, prognosis, death) were only outlined via a literature-based list provided to participants. This vagueness could lead to inconsistent interpretations, affecting response validity.

6) ***Time Constraint Oversight:*** While the ED's time-pressured environment was acknowledged, the study failed to quantify how time availability influenced personnel performance (e.g., the average duration of BBN interactions). This omission might have limited contextual analysis of suboptimal performance.

7) ***Extending Insights to Tailor Bad-News Delivery Protocols:*** Effective delivery of bad news is a recipient-centered approach [7]. The patients' high attitude scores (59.66±7.66) reflected strong preferences and an expectation gap, particularly regarding privacy, eye contact, and advance notice. However, the study could have further explored how these insights could guide the restructuring of ED resources or developing tailored BBN protocols for Iranian emergency departments.

This study provided valuable insights into the gap between ED personnel performance and patient preferences in BBN, supported by a solid methodological foundation. However, its impact was limited by its restricted generalizability, reliance on subjective performance measures, and lack of nuanced interpretation or practical implementation strategies. To strengthen future research, investigators should incorporate observer validation methods, categorize bad news scenarios according to their severity of impact, and quantify how time constraints affect communication in the ED. The development of a structured Bayesian Belief Network (SBBN) protocol that systematically integrates patient preferences with cultural considerations could significantly enhance communication strategies. By addressing these limitations, subsequent studies could evolve beyond descriptive findings to make transformative contributions that improve communication practices in emergency medicine.

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