



## Original Research Article

## Perspectives of ‘Bad News’ and its delivery: A mixed-methods study from the context of Cardiorespiratory Physiotherapy

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### Abstract

**Background:** “Bad News” is equated with terminal diagnoses in healthcare. However, in cardiopulmonary physiotherapy, patients may interpret Bad News as information about irreversible functional limitations, oxygen dependency, or life-disrupting contexts rarely examined in the literature.

**Objective:** To explore patient and physiotherapist perceptions of Bad News and understand expectations around its communication in cardiovascular and respiratory physiotherapy.

**Materials and Methods:** A mixed-methods study was conducted in the physiotherapy outpatient department (OPD) of a tertiary hospital. A validated, structured questionnaire was administered to 150 adult patients (aged 20–70 years) with cardiac or respiratory conditions to assess perceptions, emotional responses, and communication preferences. Qualitative data were collected through two patient focus group discussions (FGDs), one FGD with experienced physiotherapists, and expert interviews with communication experts.

**Results:** Survey responses demonstrated that 28% of patients associated “Bad News” with fear, 20.7% with stress, and 15.3% with existential reactions, such as “why me?”; 93% of participants preferred to receive Bad News from their treating doctor, in a private setting, with honesty and empathy. Qualitative findings revealed that Bad News was commonly linked to the loss of function, work roles, or autonomy rather than diagnosis. Physiotherapists expressed emotional burden in delivering such news and reported minimal formal training. Expert interviews emphasized contextual sensitivity, gradual disclosure, and the ethical imperative for structured communication education in physiotherapy.

**Conclusion:** Bad News in cardiopulmonary physiotherapy encompasses more than diagnosis, involving loss of function, independence, and identity. Patients desired honest yet empathetic communication tailored to their context. There is a critical need to embed communication ethics training in physiotherapy education for recognizing the role of physiotherapists in breaking and contextualizing Bad News.

**Keywords:** Bad News, Communication, Truth disclosure, Cardiac rehabilitation, Pulmonary rehabilitation, Ethics, Patient satisfaction, Qualitative research

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### 1. Introduction

Bad News is traditionally associated with terminal diagnoses; however, in clinical reality, it encompasses a broad range of situations.<sup>1</sup> Bad News is defined as “*any news that drastically and negatively alters the patient’s view of her or his future*” highlighting that it may include diagnoses such as multiple sclerosis, fetal demise, or the onset of chronic illnesses like diabetes.<sup>2</sup> The emotional impact of such communication extends beyond the moment of disclosure and can influence patient coping, psychological well-being, and engagement

in physiotherapy.<sup>3</sup> Patients frequently receive news about disease progression, loss of function, chronicity, or therapeutic limitations, which can disrupt future expectations and life roles.<sup>4</sup>

Breaking Bad News (BBN) is but is an essential component of ethical communication across the care continuum, not confined to end-of-life care. Physiotherapists often play a sustained role in a patient’s care where

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challenging conversations occur explaining chronic disability, dependency, or prognosis.<sup>5</sup> Bad News includes not just diagnostic disclosures, but also information about chronic disease progression, oxygen dependence, functional loss, or permanent work restrictions. Physiotherapists may be the first or most frequent point of contact in rehabilitation settings.<sup>6</sup> Discussions around treatment non-response, long-term limitations, or the need for lifestyle changes are emotionally significant and ethically sensitive.

Delivery of BBN has been studied in oncology and critical care, & neurorehabilitation, yet the literature on physiotherapy is sparse.<sup>7</sup> There has been negligible literature on cardiorespiratory physiotherapy facing similar morbidity or how they perceive or receive difficult information. Understanding these perceptions is essential to develop communication strategies that align with patient expectations and clinical realities, especially with the growing role of physiotherapists in patient education and chronic disease management.<sup>8</sup> Addressing this gap, the present study aimed to explore perceptions of Bad News in cardiorespiratory rehabilitation to understand their expectations regarding its delivery.<sup>9</sup>

## 2. Materials and Methods

This is a mixed-method study where a cross-sectional quantitative survey was conducted along with qualitative thematic analysis from focus group discussions (FGD) and expert interviews. Ethics approval was obtained from the Institutional Review Board, and participants provided written informed consent. The study was conducted in the Cardiovascular and Respiratory Physiotherapy Outpatient Department (OPD) of a tertiary care teaching hospital. We adopted a pragmatic approach in a single-centre setting with 150 participants based on the average outpatient attendance of Cardiovascular and respiratory physiotherapy OPD over a 3-month period for enhancing internal validity for real-world representation using consecutive sampling for a descriptive study design with 100–200 respondents. Quantitative component included 150 adult patients aged 20–70 years with primary cardiovascular or respiratory (CVR) diagnoses, enrolled through complete enumeration based on OPD attendance. A pre-tested, validated, structured interview schedule collected data on demographics, patient perceptions of Bad News, preferred communication style and setting, and past experiences with receiving difficult information. The tool was face-validated by subject experts and administered by trained postgraduate physiotherapy students fluent in English, Marathi, and Hindi.

We conducted three FGDs and one expert interview based on principles of information power and data saturation. The number of FGDs was determined by the point at which no new themes emerged during the thematic analysis, indicating saturation. The qualitative component included two FGDs with 8 patients each and one FGD with 10 physiotherapists with at least 10 years of experience in cardiorespiratory physiotherapy from varied states of India. A key informant

interview was conducted with an expert in healthcare communication, education, and ethics. Triangulation and thematic depth were strengthened through the inclusion of diverse stakeholders, including patients, experienced physiotherapists, and a communication expert. The FGDs and interviews were guided by semi-structured question sets designed to explore what constitutes “Bad News” in physiotherapy and how patients expect such information to be delivered. FGDs were held in private settings, audio-recorded, and lasted 45–60 minutes. Expert interviews explored ethical frameworks, barriers, and communication strategies relevant to physiotherapy practice. Qualitative data were transcribed and analysed theoretically using Braun and Clarke’s six-step framework.<sup>10</sup> The methodological triangulation of quantitative data with qualitative insights from patients, therapists, and faculty experts provided a multi-dimensional understanding of patient-centred communication in cardiovascular and respiratory physiotherapy. The triangulated approach enriched data interpretation and validated key themes that emerged from the survey, deepening the contextual understanding of how patients and physiotherapists experience and navigate Bad News in clinical rehabilitation settings.

## 3. Results

### 3.1. Demographics

The 150 participants had a mean age of  $51.26 \pm 15.94$  years, median age of 56 with age range spanning from 18 to 88 years. Age distribution was found to be non-normal based on the Shapiro-Wilk test ( $p < 0.001$ ). Majority of participants identified as Hindu (88%), were married (75.3%), and belonged to nuclear families (78.7%). In terms of educational background, 32% had completed secondary education and 27.3% were graduates, while smaller proportions were either illiterate (6.7%) or held professional degrees (5.3%). Regarding income, most participants (72%) reported earning between ₹10,000 and ₹1,00,000 per month, with 12% earning less than ₹10,000 and 7.3% earning more than ₹1,00,000. 83.3% sought treatment at government or BMC hospitals, 14.7% went to private hospitals, and 2% went to private clinics. Most patients presented with cardiovascular (56.7%) or respiratory (38%) issues, and the majority of patients were treated by cardiologists and chest physicians (46.7% and 44.7%, respectively). Asthma (11.3%), interstitial lung disease (8%), ischemic heart disease (34.7%), and tuberculosis (12%) were the most common diagnoses. Comorbidities, with diabetes (19.3%) and hypertension (60.7%) being the most prevalent in 68% of individuals

### 3.2. Quantitative analysis

Participants were asked to describe what came to mind when they heard the phrase “Bad News.” In the first word category, fear was the most common response (28%), followed by stress (20.7%), “why me?” (4.7%), tension (8%), and death (4.7%). Interestingly, 15.3% of participants responded with words reflecting resilience or acceptance, such as “no fear” or “positive acceptance.” When asked for a second word association, 23.3% responded with “tension,”

16.7% with “fear,” and 6% with “stress,” while 32.7% did not respond. For the third word, “why me?” was a prominent response (15.3%), followed by “stress” (12.7%) and “tension” (10%). However, 40% left the third word blank, suggesting possible emotional fatigue or difficulty articulating further associations. Among the participants, 68% had previously experienced receiving Bad News related to their health or that of a close family member. These instances were commonly linked to diagnoses (e.g., ischemic heart disease, tuberculosis, or cancer), major surgical recommendations (e.g., coronary bypass), or prognostic disclosures. When asked to rate their experience, 38.7% described it as “good,” 19.3% as “better,” while 42% rated it as “bad” or “worst,” highlighting a substantial emotional impact of such conversations. In terms of communication preferences, 93% of participants expressed that they preferred Bad News to be conveyed directly by the treating doctor, and 86% preferred that it be delivered in a private, quiet setting. Most participants favoured a communication style that was honest, simple, and devoid of medical jargon. 61% stated that they preferred to be comforted through positive and empathetic words, while a smaller proportion indicated a preference for minimal emotional involvement from the healthcare provider. When asked about the type of information they expected during such conversations, patients frequently mentioned wanting clear answers regarding the diagnosis, treatment options, prognosis, and next steps in care.

#### 4. Qualitative Findings

##### 4.1. Patient perceptions of Bad News

BBN went beyond a life-threatening diagnosis, according to thematic analysis of patient FGDs. Any threat to their autonomy, daily functioning, or capacity to support their families was viewed negatively by the patients. Important instances included being informed that they had to quit their job, being put on oxygen therapy for the rest of their lives, or learning that they had a chronic condition such as post-tuberculosis lung fibrosis or heart failure.

1. *“It’s horrible news if I’m informed, I’ll need to be on oxygen for the rest of my life.”*
2. *“It feels like a death sentence to be informed that I can’t work or that I require assistance using the restroom.”*

Survey data revealed that words like “why me?” (15.3%), “worry,” and “fear” (28%), dominated the emotional connotations with BBN. Patients focused more on the emotional toll of limits than the actual illness, particularly when these changes interfered with their family function. Some wanted direct and open communication, highlighting their emotional readiness, others had conflicting opinions regarding disclosure, preferring that family members be given comprehensive information first. **(Table 1) and (Table 2)**

**Table 1:** Thematic analysis of patient’s focused group discussions, cardiorespiratory physiotherapist’s perspective and expert interviews

A. Themes identified from patient's focused group discussions			
S. No.	Theme	Illustrative quotes	Interpretation
1.	Functional loss as Bad News	<i>“If I have to use oxygen forever, that’s worse than a disease name.”</i>	Long-term disability implies a loss of future identity and normalcy. Oxygen use becomes a visible marker of illness and limitation, reinforcing stigma and emotional burden.
		<i>“Being told I can’t walk to the bathroom alone—that’s Bad News.”</i>	Patients perceive loss of function—rather than the diagnostic label itself—as the true marker of “Bad News.
2.	Emotional overload and Fear	<i>“I was scared, confused... my mind went blank.”</i>	Emotional responses ranged from fear to disbelief, especially when prognosis was poor or functional loss was long-term.
3.	Role of work and family responsibility	<i>“If I can’t work, how will I support my family?”</i>	Patients linked Bad News to disruption of earning ability and fulfilling family responsibilities.
4.	Need for honesty with sensitivity	<i>“Tell me the truth, but don’t dump it all at once.”</i>	Most patients preferred phased information, preferably with family present.
5.	Respect for individual coping styles	<i>“I didn’t want to know everything—I asked my son to talk instead.”</i>	Patients expressed differing levels of readiness for full disclosure.
B. Themes identified cardiorespiratory physiotherapist's perspective			
1.	Functional news as core burden	<i>“We often have to tell them they won’t go back to work.”</i>	Therapists described the responsibility of sharing long-term limitations in activity or independence.

S. No.	Theme	Illustrative Quotes	Interpretation
2.	Therapist emotional strain	<i>“We carry the burden too... it's hard to crush their hope.”</i>	Revealing non-recovery scenarios caused emotional exhaustion.
3.	Gaps in communication training	<i>“We never learned how to say this gently.”</i>	Most had no formal training in delivering difficult conversations.
4.	Strategies used informally	<i>“I use analogies... compare rehab to a mountain climb.”</i>	Gradual disclosure, goal reframing, and collaborative planning were common.
5.	Ethical conflict between hope and truth	<i>“How do I motivate and still tell them it won't be the same?”</i>	Therapists struggled with maintaining optimism without misleading the patient.
<b>C. Themes identified from expert interview</b>			
1.	Redefining Bad News	<i>“Bad News is not just death or cancer—it's anything that changes your life permanently.e.g., need for oxygen, functional dependence, long-term treatment.”</i>	Broadens the concept of Bad News to include life-altering but non-terminal conditions (e.g., chronic illnesses, permanent functional limitations).
2.	Functional loss as central to distress	<i>If a patient is told he can't work again, that's often more shocking than being told he has fibrosis.”</i>	Functional limitations—loss of independence, mobility, or occupation—are experienced as more distressing than diagnostic labels. thus represent “Bad News” even when the diagnosis is not terminal.
3.	Patient age and life stage matter. communication should be contextual	<i>“A 27-year-old being told she can't work again is worse than a 90-year-old with a cardiac arrest.”</i>	Younger patients perceive Bad News more severely due to disrupted responsibilities, career aspirations, and identity formation. Communication should be tailored to the patient's age, life stage, and cultural background.
4.	Social and family role amplify impact	<i>“He's the only earning member—being told he'll need support is a major shock to the family.”</i>	Patients' social and familial roles shape the perceived burden of Bad News, especially in collectivist contexts like India.
5.	Gradual disclosure and emotional readiness	<i>“You first ask—what do they know already? Then build the rest from there.”</i>	Advocates a stepwise, patient-centered approach to disclosure that gauges emotional and cognitive readiness before delivering full information.
6.	Relational analogies for framing	<i>“Rather than saying it's cancer, I say—this is what we found, these are the changes, here are the options.”</i>	Analogies and relational questioning allow patients to understand and process complex or distressing information in a more empathetic and reflective manner.
		<i>“Then I ask: if this was your sister, what would you do?”</i>	
7.	Importance of empathy and time	<i>“Sometimes just five extra minutes makes the patient feel heard.”</i>	Emphasizes that non-verbal cues, tone, presence, and emotional availability are essential components of breaking Bad News effectively.
		<i>“What you say matters, but how you say it matters more.”</i>	
8.	Need for ethical communication training and systems perspective	<i>“Young doctors are technically skilled, but no one teaches them how to break news with empathy.”</i>	Calls for structured ethics and communication training in health professions to prepare clinicians for emotionally complex interactions and for hospital systems to support time-bound, private, and emotionally safe disclosures.

**Table 2:** Interview guide for focused group discussions

<b>A. Focus group discussion guide</b>	
1.	What do you understand by ‘Bad News’?
2.	What do you feel is Bad News for you?
3.	What is it that you feel not good about because of the illness?
4.	Has any physiotherapist ever told you something which you perceived as Bad News?
5.	How do you feel about possible limitations told to you because of illness?
6.	How were you told/informed?
7.	Do you recollect any word or any sentence told to you about your illness by a therapist or doctor which you feel was Bad News?
8.	How was the experience?
9.	How would you have liked it to be informed?
<b>B. Faculty experts: Interview guide for key informant interview</b>	
1.	What is your perception of what constitutes Bad News for patients with cardiorespiratory diseases?
2.	Why do you feel these are Bad News?
3.	Have any patient communicated their experience of Bad News to you? Can you narrate.
4.	How should Bad News be broken?
5.	Are you aware of any module of breaking Bad News?
6.	Do you follow any steps for breaking Bad News?
7.	What are the barriers for breaking Bad News?
8.	How can we facilitate breaking Bad News?

### 5. Physiotherapist Perspectives

Physiotherapists reported negative outcomes, including functional limits, lack of progress despite treatment, and a reliance on long-term assistance like oxygen or mobility aids. For instance, one therapist explained:

*“The patient was a senior engineer with career goals. We had to tell him he couldn’t climb stairs without a walker. It was difficult for us to say, but it was awful for him.”*

Other therapists shared their internal conflicts:

1. *“When I know my rehab won’t help the patient get back to work... that’s Bad News I have to break.”*
2. *“It’s not just about physical limits—it’s the loss of what they expect to regain. That disconnect is what hurts.”*

Physiotherapists also identified the lack of formal communication training as a barrier, relying on intuition and experience to frame difficult conversations. Many shared instances of drawing on analogies, engaging family members, or gradually introducing limitations through functional goal-setting. **Table 1** identifies themes from physiotherapist’s perspective.

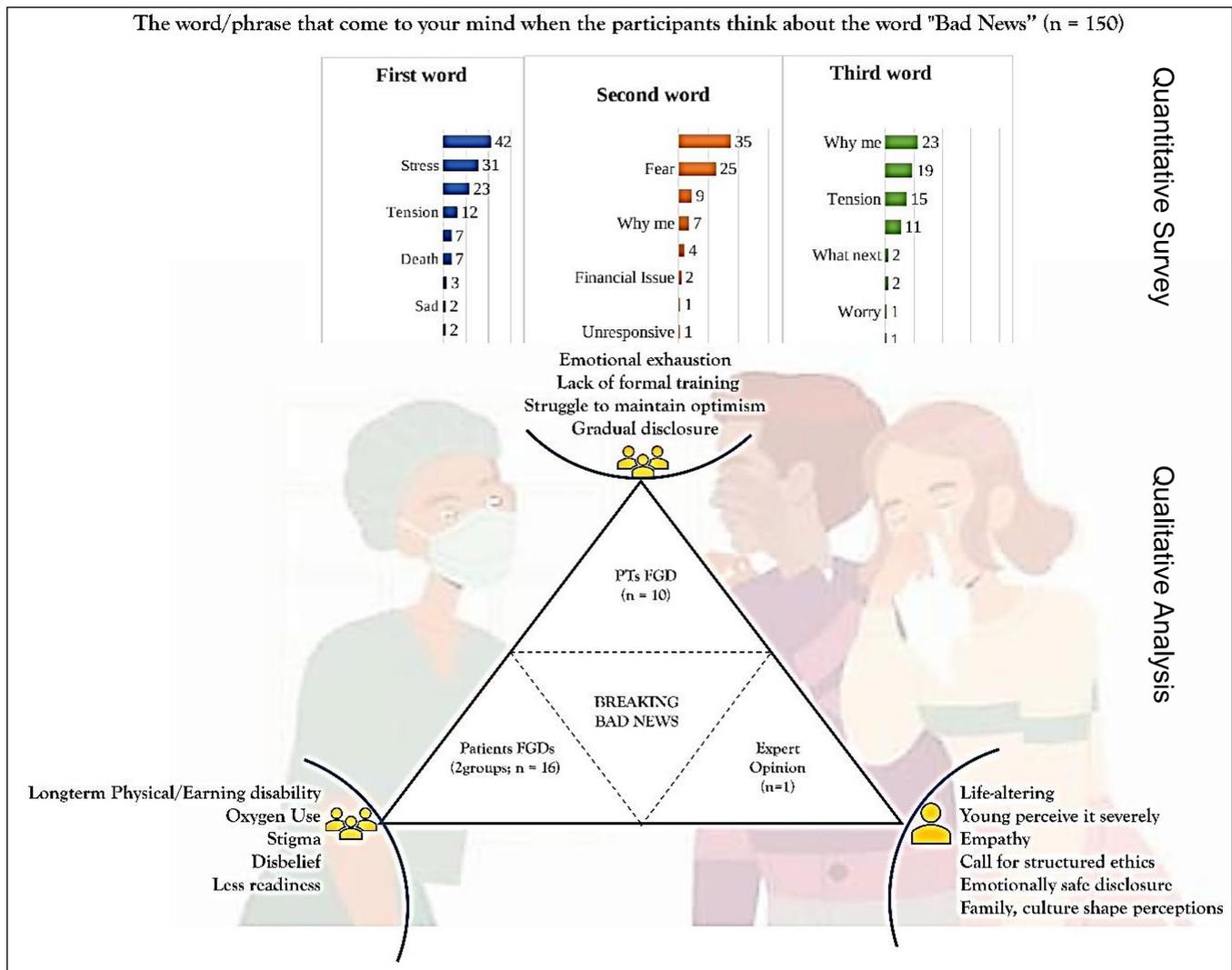
### 6. Expert Interview

An in-depth interview with a senior medical educator and bioethics expert provided critical ethical and contextual

insights into the communication of Bad News within rehabilitation settings. The expert broadened the definition of Bad News beyond terminal diagnoses, emphasizing that functional impairment, loss of autonomy, and disruption of social roles often carry more emotional weight for patients than the diagnosis itself. Age, life stage, and family responsibilities particularly for younger individuals who are primary earners, were identified as significant factors shaping how Bad News is received, often amplifying the emotional impact of information related to irreversible limitations.

The expert advocated for a culturally sensitive, stepwise approach to disclosure, recommending that clinicians begin by assessing what the patient already knows, then progressively introducing information using analogies and patient-centred language. Structured communication when aligned with frameworks such as SPIKES Protocol (Setting, Perception, Invitation, Knowledge, Empathy, and Strategy) expert’s approach places additional emphasis on contextual sensitivity and relational ethics.

Echoing the perspectives of physiotherapists in this study, the expert called for integrating formal training in ethical communication within physiotherapy curricula. The expert also stressed the need for institutional support that ensures clinicians have the time, privacy, and emotional bandwidth to engage in such conversations with empathy and clarity. Expert’s views were strongly aligned with both patient and therapist perspectives, reinforcing the triangulated findings. **(Figure 1)**



**Figure 1:** An illustration of triangulated framework of core themes of breaking Bad News in cardiorespiratory physiotherapy.

### 7. Discussion

The mixed-methods study explored the perceptions and expectations of patients receiving “Bad News” in the context of cardiovascular and respiratory physiotherapy. Findings reveal that BBN in the OPD setting extends beyond terminal diagnoses including chronicity, functional decline, oxygen or device dependency, and disruption of life roles such as employment and social autonomy. Patients internalized Bad News not only as clinical information but as a lived experience marked by emotional distress, daily disruption, and perceived loss of future potential. These insights align with Quill’s observation that Bad News is interpreted through psychophysiological, cognitive, and affective lenses unique to each patient. In our study, distress was linked less to the diagnosis itself and more to its implications, such as inability to work, reduced mobility, or loss of identity. This highlights the importance of clinicians exploring patient interpretations before engaging in shared decision-making.<sup>11</sup>

#### 7.1. Redefining “Bad News” in rehabilitation contexts

Traditionally, Bad News is defined in the context of life-threatening conditions. However, in physiotherapy,

particularly cardiorespiratory care, the definition broadens to include non-reversible disease progression, chronic functional limitations, and reduced ability to participate in meaningful activities. Our findings support this expanded conceptualization, with 28% of participants associating Bad News with fear, 20.7% with stress, and many spontaneously voicing existential reactions such as “why me?”. These findings resonate with Gregg’s definition as “any information that negatively alters a person’s view of their future” and highlight that the concept of BBN is perceived as a complex existential event by patients with cardiopulmonary conditions regarding medical progress, recovery of function, quality of life, and return to job.

Clinically, patients with conditions such as interstitial lung disease, heart failure, or post-tuberculosis pulmonary impairment often face significant limitations despite medical intervention. The requirement for long-term oxygen therapy, restricted mobility, or cessation of employment all frequently communicated during physiotherapy, was experienced as emotionally disruptive even in non-terminal stages of disease.<sup>12</sup>

### 7.2. Emotional complexity and communication breakdown

68% of patients in this study reported prior experiences of receiving Bad News, only 38.7% rated those conversations as “good” or “better,” while 42% classified them as “bad” or “worst.” This disparity points to a persistent communication gap, one in which the manner, setting, or emotional tone of delivery often fails to align with patient expectations or readiness. Ishaque & colleagues reported similar patient expectations during BBN and found that 40.5% of respondents felt it was the patient’s absolute right to be informed honestly and directly.<sup>13</sup> Despite this, nearly half reported that their experiences of BBN had been incomplete or emotionally unhelpful. Their findings reinforce our survey result that most patients preferred Bad News to be delivered by the treating physician, privately and honestly, reflecting shared expectations across cultural contexts. Seifart & colleagues reported dissatisfaction among cancer patients, with 46.2% fully satisfied with how Bad News was delivered, even when the SPIKES framework was used.<sup>14</sup> Dissatisfaction was significantly correlated with emotional distress ( $r = -0.261$ ,  $p < 0.001$ ), suggesting that structured models may not fully accommodate the individual variability in how patients prefer to receive difficult information. These findings emphasize the need to adapt communication strategies to sociocultural and patient-specific contexts.

In our study, 93% of participants expressed a strong preference for Bad News to be delivered by their treating physician in a private setting. However, qualitative narratives revealed considerable variation in the degree and manner of disclosure that patients preferred. While some valued full transparency, others preferred a filtered or family-mediated approach, highlighting the importance of individualized, culturally sensitive communication strategies.

### 7.3. The role and burden of the physiotherapist

A key insight from FGDs with physiotherapists was emergence of “functional Bad News” disclosures about irreversible loss of function, independence, or role fulfilment. Physiotherapists are tasked with explaining limitations around recovery, work, or lifestyle, which can generate ethical tension. PTs reported experiencing moral distress, particularly when patient goals were unrealistic or when they lacked the training to manage such conversations empathetically.<sup>15</sup> These challenges mirror those reported in other healthcare settings. A review highlighted the difficulty clinicians face when BBN reaches emotionally vulnerable groups such as children, young adults, or those with low health literacy. They emphasized that poor settings and lack of strategy often undermine such interactions, issues similarly raised by physiotherapists in our study.<sup>16</sup>

The emotional toll of these situations aligns with the concept of moral distress, where healthcare providers feel constrained from acting ethically due to systemic limitations or lack of preparedness.<sup>17</sup> One therapist poignantly stated, “We limit them to the real-life scenario,” yet are expected to motivate and inspire hope, reflecting a

complex dual responsibility. This balance between truth-telling and compassion is a critical ethical skill currently underrepresented in physiotherapy education. Established protocols may not align with patient priorities. The Seifart study’s findings suggest that structured frameworks like SPIKES may inadequately address emotional or cultural nuances, reinforcing the need for tailored approaches in physiotherapy communication.<sup>18</sup>

### 7.4. Broadening the scope: Physiotherapists in the BBN process

Literature on BBN centres on physicians during acute consultations. Anestis & colleagues demonstrated that non-medical professionals, including physiotherapists, play a central role in reinforcing and contextualizing Bad News, particularly in chronic and neurodegenerative conditions. Their study highlights that BBN is not a one-time event but an evolving process that often unfolds across disciplines.<sup>19</sup> Our findings corroborate this, showing that physiotherapists are routinely involved in conversations about non-recovery, adjustment, and long-term support.

### 7.5. Need for structured training and ethical preparedness

Despite playing a pivotal role in rehabilitation, most physiotherapists in our study reported a lack of formal training in BBN. Communication strategies employed using analogies, reframing goals, or involving family members, which were largely developed informally through clinical experience rather than structured instruction. This highlights a critical educational gap. Incorporating established communication frameworks (SPIKES or COMFORT), though originally developed in oncology and palliative care, could offer physiotherapists structured guidance to navigate emotionally complex conversations. Embedding bioethics education with a focus on patient autonomy, shared decision-making, and emotional intelligence may better equip physiotherapists to approach these interactions with ethical sensitivity and empathy. Our findings support the need for interprofessional collaboration, especially in chronic or palliative care, where coordinated communication among physiotherapists, physicians, and allied professionals enhances both patient understanding and emotional support.<sup>20</sup> Our observations are supported by findings from Sengupta & colleagues, who explored communication challenges in private healthcare settings in West Bengal. The study identified barriers such as language differences, limited health literacy, and ethical-moral conflicts, particularly in discussions involving death or terminal illness.<sup>21</sup> Effective communication is influenced not only by training or message content, but also by the setting, interpersonal dynamics, and perceived relational trust. Together, these insights underscore the need for contextualized, culturally sensitive communication frameworks in Indian healthcare practice.<sup>22</sup>

### 7.6. Triangulated interpretation of findings

Convergence of quantitative data, qualitative FGDs, and expert interviews revealed a nuanced, function-centred

understanding of Bad News in physiotherapy. While survey responses emphasized emotional terms like “fear,” “stress,” and “why me?”, the qualitative narratives gave context linking these emotions to loss of independence, occupational identity, and life roles.<sup>23</sup>

Triangulation confirmed that functional loss, rather than only diagnostic labelling, is often the primary source of distress, particularly when it compromises economic security or future expectations. These insights are reinforced by expert opinion, highlighting that “Bad News is not cancer—it is anything that changes the way you live.”<sup>24</sup> Physiotherapists, although not typically the first to disclose diagnosis, frequently carry the emotional burden of explaining non-recovery, limitations, and the realities of long-term care. Across all data sources, a common theme emerged: the urgent need for structured training in ethical, culturally sensitive, and function-focused communication. This integrated understanding offers a holistic framework for improving patient-centred communication in rehabilitation settings, particularly within the socio-cultural landscape of Indian healthcare.<sup>25</sup>

## 8. Conclusion

Our study offers a detailed, patient-centred perspective on the communication of Bad News in cardiorespiratory physiotherapy. Through the triangulation of patient experiences, physiotherapist insights, and expert ethical viewpoints, it becomes evident that Bad News in rehabilitation is often rooted not in diagnosis or mortality, but in the loss of function, autonomy, and life roles. Patients expressed a clear preference for communication that is empathetic, honest, and tailored to their readiness and sociocultural context. Physiotherapists, who frequently communicate the functional implications of illness, require both structured communication tools and ethical training to navigate these emotionally complex conversations. Communication of Bad News should therefore be recognized as a core competency in physiotherapy, particularly in cardiorespiratory and chronic care. Educational programs should integrate validated models, along with interprofessional training that fosters collaboration with physicians and mental health professionals. Future research can evaluate the effectiveness of training interventions focused on improving patient satisfaction, engagement, and care outcomes.

## 9. Limitations

Generalizability of findings to cultural and clinical settings is the primary limitation of our study as it was conducted in a single tertiary care centre. Qualitative responses in FGDs may have been influenced by group dynamics or social desirability bias. Future research could expand this work across multiple centres and include diverse demographic and sociocultural populations to enrich external validity.

## 10. Implications for Practice and Research

BN can be viewed as a core competency in physiotherapy especially in cardiorespiratory physiotherapy in chronic

care settings. Undergraduate & postgraduate physiotherapy curricula ought to integrate structured training in communication ethics inclusive of SPIKES & COMFORT (Communication, Orientation, Mindfulness, Family, Ongoing, Reiterative, and Team) models. Physiotherapists must be trained to collaborate inter-professionally with psychologists, physicians in delivering layered patient-sensitive disclosures. Evaluation of communication & ethics training outcomes on patient satisfaction can be studied futuristically in physiotherapy.

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## 12. Conflict of Interest

None.

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