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Patient-Focused Communication Practices of Nigerian Medical Officers When Conveying Adverse Diagnoses: An Integrative Narrative Review and Context-Sensitive Practice Framework

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Abstract

Conveying an adverse diagnosis is among the most ethically sensitive and emotionally demanding duties of medical practice. In Nigeria, adverse diagnosis communication occurs within a pluralistic health system marked by family involvement, religious meaning-making, language diversity, variable health literacy, resource constraints, and hierarchical doctor-patient relations. Although structured breaking-bad-news models such as SPIKES are widely cited, the extent to which these models are patient-focused and contextually adapted in Nigerian practice remains an important scholarly and clinical question. This article synthesised current evidence on patient-focused communication practices among Nigerian medical officers and related physician groups when conveying adverse diagnoses and proposed a context-sensitive framework for improving disclosure practice, training, and institutional support. An integrative narrative review was conducted using accessible peer-reviewed and policy-relevant literature on breaking bad news, patient-centered communication, Nigerian doctor-patient interaction, and communication barriers in sub-Saharan African clinical settings. Evidence was synthesized thematically around protocol use, patient autonomy, family and cultural mediation, emotional support, religious/spiritual considerations, health-system constraints, and communication training. The reviewed evidence suggested that Nigerian doctors increasingly recognized the importance of structured, patient-focused disclosure. A recent cross-sectional study among 245 Nigerian doctors reported 72.7% full adherence to SPIKES, with very high reported adherence to knowledge sharing, setting, empathy, and strategy, but weaker adherence to invitation, which concerns how much information the patient wishes to receive (Ipinnimo et al., 2025). A qualitative study of Nigerian clinical oncologists found that breaking cancer news was overwhelming, required individualized communication, should keep the patient as the primary focus, and was constrained by workload and insufficient training (Okoye et al., 2024). Broader Nigerian communication research indicated that clinical encounters may remain doctor-centered because of power distance, limited disclosure depth, insufficient empathy, and institutional weaknesses in patient-centered care (Adam, 2014; Adebayo, 2021; Akinkurolere, 2022; Lateef & Mhlongo, 2022). The synthesis led to the development of RESPECT-NG, a six-domain framework: Readiness and setting; Explore perception and disclosure preference; Share knowledge plainly; Pause for emotion, family, and spiritual meaning; Enable decisions and next steps; and Continuity, team support, and navigation. Patient-focused adverse diagnosis communication in Nigeria requires more than technical delivery of diagnostic information. It requires ethically grounded, culturally responsive, emotionally supportive, and system-enabled communication. The proposed RESPECT-NG framework may inform medical education, continuing professional development, hospital policy, and future empirical research on adverse diagnosis disclosure in Nigeria.

Keywords: adverse diagnosis; breaking bad news; doctor-patient communication; medical officers; Nigeria; patient-centered care; SPIKES; health communication

Introduction

Conveying an adverse diagnosis is a pivotal moment in the clinical relationship because it can alter a patient's expectations, identity, treatment decisions, family roles, spiritual interpretation of illness, and trust in the health system. Bad news has classically been defined as information that seriously and adversely affects an individual's view of the future (Buckman, 1992). In clinical practice, such information includes diagnoses of cancer, advanced organ failure, fetal loss, stroke complications, congenital anomalies, irreversible disability, terminal illness, serious infectious disease, and poor prognosis after medical interventions. The communication of adverse diagnoses therefore requires more than accuracy; it requires sensitivity, preparation, emotional containment, ethical clarity, and continuity planning.

The challenge is particularly important in Nigeria, where medical officers and other frontline doctors often manage large patient loads across public and private facilities and communicate with patients whose preferences are shaped by family structures, religious belief, socioeconomic constraints, and uneven health literacy. Nigerian patients may present late because of cost barriers, low awareness, fear, alternative health-seeking pathways, or limited access to specialist care. Consequently, doctors may have to disclose diagnoses at advanced stages, when curative options are limited and emotional reactions are intense. In this context, patient-focused communication is not a peripheral interpersonal skill; it is a core dimension of quality, safety, dignity, and ethical care.

Internationally, the SPIKES protocol has become one of the most influential frameworks for breaking bad news. SPIKES encourages clinicians to set up the interview, assess the patient's perception, obtain the patient's invitation to receive information, share knowledge, respond empathically to emotions, and summarize strategy or next steps (Baile et al., 2000; Rosenzweig, 2012). The protocol is valuable because it converts a difficult encounter into a learnable sequence. However, patient-focused communication requires careful adaptation to the social and institutional conditions of practice. A scripted sequence may be insufficient when the patient speaks a different language from the doctor, when relatives seek to control information, when the patient prefers spiritual framing, when privacy is unavailable, when clinics are overcrowded, or when the doctor has had little formal training in disclosure.

Recent Nigerian evidence has begun to clarify these issues. Ipinnimo et al. (2025) found that 72.7% of surveyed doctors in Ekiti State reported full adherence to SPIKES, but the invitation component remained less consistently practiced than other components. This finding is important because invitation is closely related to patient autonomy, preference-sensitive disclosure, and shared decision-making. In oncology, Okoye et al. (2024) reported that Nigerian clinical oncologists perceived bad-news communication as overwhelming and training-dependent, while also emphasizing that patients should remain the primary focus and that each disclosure process should be individualized. These findings suggest that Nigerian clinicians recognize the moral and relational weight of adverse diagnosis communication, but they also practice under constraints that may reduce the consistency of patient-focused care.

This article synthesized current evidence on patient-focused communication practices of Nigerian medical officers and related physician groups when conveying adverse diagnoses. It also proposed a context-sensitive practice framework designed for Nigerian clinical settings. The term medical officers is used in the Nigerian sense to refer primarily to licensed doctors who provide direct patient care and may not yet be consultants; however, because published Nigerian evidence often includes doctors across cadres, the review also drew on studies involving broader physician groups. The article was guided by three questions: What communication practices are reported among Nigerian doctors when conveying adverse diagnoses? What contextual factors shape patient-focused disclosure in Nigerian clinical settings? How can adverse diagnosis communication be improved through a locally responsive framework for practice, training, and institutional support?

Conceptual Background

Patient-focused communication is closely related to patient-centered care, but it has a specific emphasis on the communicative actions by which clinicians recognize the patient as a person, not merely as a bearer of disease. Epstein and Street (2007) argued that patient-centered communication in cancer care involves fostering healing

relationships, exchanging information, responding to emotions, managing uncertainty, making decisions, and enabling self-management. These domains are directly applicable to adverse diagnosis disclosure because such encounters often combine uncertainty, fear, complex information, urgent decisions, and a need for continued support.

In the Nigerian setting, patient-focused communication must also be culturally and institutionally situated. Studies of doctor-patient interaction in Nigeria have shown that clinical encounters may be shaped by power asymmetry, doctor-centered questioning, limited patient participation, and culturally embedded expectations of professional authority (Adam, 2014; Adebayo, 2021; Akinkurolere, 2022). These patterns do not imply that Nigerian doctors are indifferent to patients. Rather, they suggest that communication practices are produced through social norms, training traditions, workload pressures, and institutional arrangements that may privilege biomedical explanation over relational understanding.

A patient-focused approach to adverse diagnosis communication should therefore integrate three domains. The first domain is clinical truthfulness, which requires that the diagnosis and prognosis be communicated accurately and intelligibly. The second is relational responsiveness, which requires that the doctor attend to the patient's emotions, values, family context, and readiness. The third is systemic responsibility, which requires that hospitals create conditions for privacy, adequate consultation time, language support, referral pathways, and clinician training. These domains align with SPIKES but extend beyond it by emphasizing the Nigerian realities of family mediation, spiritual interpretation, and resource-constrained care.

Methods

Design

This article used an integrative narrative review design. This design was appropriate because the topic involves empirical evidence, communication theory, cultural analysis, clinical ethics, and practice recommendations. The aim was not to estimate a pooled effect size but to synthesize heterogeneous evidence and develop a practical framework for Nigerian clinical settings. Integrative narrative reviews are particularly useful when a topic is emerging, interdisciplinary, and not yet supported by a large number of comparable quantitative studies.

Sources and Search Orientation

The review drew on peer-reviewed and policy-relevant literature concerning breaking bad news, patient-centered communication, Nigerian doctor-patient interaction, and disclosure challenges in sub-Saharan African healthcare. Searches were oriented toward combinations of terms such as breaking bad news, adverse diagnosis, SPIKES, Nigeria, doctor-patient communication, patient-centered communication, oncology disclosure, medical officers, patient-centered care, and sub-Saharan Africa. Priority was given to recent Nigerian studies, foundational communication frameworks, and accessible full-text sources with clear relevance to clinical disclosure.

Inclusion Logic

Sources were included if they met one or more of four criteria. First, they directly examined breaking bad news or adverse diagnosis communication among Nigerian doctors or health professionals. Second, they examined Nigerian doctor-patient communication, power relations, patient-centered care, or culturally situated clinical interaction. Third, they provided foundational frameworks for breaking bad news or patient-centered communication. Fourth, they discussed disclosure barriers relevant to sub-Saharan African healthcare settings. Sources were excluded from substantive synthesis if they were not related to clinical communication, if bibliographic details could not be sufficiently verified, or if they offered only general commentary without relevance to disclosure practice.

Synthesis Procedure

The evidence was synthesized thematically. First, findings were grouped according to communication practices, including protocol use, information giving, empathy, invitation, family engagement, and follow-up planning. Second, contextual influences were identified, including culture, religion, language, health literacy, workload,

facility type, and training. Third, these themes were compared with patient-centered communication theory and SPIKES. Finally, a context-sensitive framework was developed to translate the synthesis into a usable structure for Nigerian medical officers.

Results: Thematic Synthesis

Reported Use of Structured Disclosure Protocols

The strongest recent Nigerian quantitative evidence comes from Ipinnimo et al. (2025), who surveyed 245 medical doctors in Ekiti State and found that 72.7% reported full adherence to the SPIKES protocol. The component-specific findings were notable: adherence was reported for Setting by 98.4%, Perception by 93.9%, Invitation by 76.7%, Knowledge by 99.2%, Empathy by 98.0%, and Strategy by 98.4% (Ipinnimo et al., 2025). These findings suggest that many Nigerian doctors are familiar with the practical logic of structured disclosure, whether through formal education, informal apprenticeship, or experiential learning.

However, the same study also revealed variation in practice. Some doctors used SPIKES variants, particularly combinations emphasizing knowledge and empathy; others reported no specific protocol; and a small number used religious/spiritual, BREAKS, ABCDE, GATHER, BATHE, blunt, or diplomatic approaches (Ipinnimo et al., 2025). This variation is clinically significant. It shows that disclosure practice is not uniform and that doctors may adapt communication to specialty, facility culture, patient characteristics, and available time. It also suggests that patient-focused disclosure cannot be assumed merely because a doctor reports using a protocol. The quality of disclosure depends on how the steps are enacted and whether the patient's informational and emotional needs are genuinely elicited.

SPIKES component	**Patient-focused meaning**	**Nigerian evidence and implication**
Setting	The doctor creates privacy, reduces interruptions, and prepares emotionally and clinically.	High reported adherence suggests recognition of the need for an appropriate environment, but overcrowding and public-facility constraints may limit practical implementation (Ipinnimo et al., 2025; Ibrahim et al., 2012).
Perception	The doctor explores what the patient already understands or suspects.	High reported adherence is encouraging because patients may arrive with explanatory models shaped by family, religion, or prior informal care (Ipinnimo et al., 2025).
Invitation	The doctor asks how much the patient wants to know and how information should be shared.	This was the weakest component in the Nigerian SPIKES study, indicating a potential gap in autonomy-sensitive disclosure (Ipinnimo et al., 2025).
Knowledge	The doctor communicates the diagnosis in plain, staged, and accurate language.	Very high reported adherence suggests comfort with biomedical explanation, but language and health literacy remain critical concerns.

Empathy	The doctor recognizes, names, and responds to emotion.	High reported adherence contrasts with broader Nigerian studies reporting empathy and interpersonal gaps, indicating a need for observational research (Adebayo, 2021; Ipinnimo et al., 2025).
Strategy/Summary	The doctor provides next steps, treatment options, referrals, and realistic hope.	High reported adherence is important in resource-constrained settings because patients need navigation support after diagnosis.

Patient as the Primary Focus

Okoye et al. (2024) provided oncology-specific evidence through a qualitative grounded theory study involving 24 clinical oncologists in Nigeria. The study identified five themes: bad-news disclosure was overwhelming; oncologists needed training in patient-doctor communication; each disclosure should be unique; patients should be the primary focus; and clinical workload affected oncologists' capacity to break bad news effectively (Okoye et al., 2024). These findings are especially relevant because cancer diagnosis often carries intense stigma, fear, financial burden, and prognostic uncertainty in Nigeria.

The theme that "patients should be the primary focus" is central to this article. A patient-focused approach does not mean excluding families, dismissing culture, or ignoring spiritual beliefs. Instead, it means that family, culture, and spirituality should be engaged in ways that protect the patient's dignity, preferences, and decision-making role. In many Nigerian contexts, relatives may be deeply involved in financing care, interpreting illness, making treatment decisions, and providing emotional support. Their role can be beneficial, but it can also become problematic if relatives request nondisclosure, dominate the encounter, or prevent the patient from asking questions. Patient-focused communication requires medical officers to negotiate this terrain respectfully and ethically.

Power Relations and Doctor-Centered Communication

Nigerian studies of clinical interaction suggest that patient-focused disclosure may be limited by power asymmetry. Adam (2014) found that physician power shaped consultation discourse in selected Lagos hospitals and recommended patient empowerment through less interruptive and less restrictive questioning. Adebayo (2021), using a critical-cultural perspective, reported low communication efficacy in Nigerian physician-patient interactions, including insufficient interpersonal connection, empathy, and depth of disclosure. Akinkurolere (2022) similarly showed that doctor-patient encounters in a Nigerian general hospital were shaped by sociocultural context and that doctors could default to doctor-centered communication when they believed patients were unable to provide adequate diagnostic information.

These findings matter for adverse diagnosis disclosure because bad news magnifies the patient's vulnerability. If the doctor dominates the encounter, the patient may leave without understanding the diagnosis, prognosis, treatment choices, or warning signs. If the doctor uses technical language, the patient may appear to consent while remaining confused. If the doctor avoids emotional engagement, the patient may experience disclosure as abandonment. Patient-focused communication therefore requires explicit effort to reduce harmful hierarchy without undermining professional clarity.

Communication Training and Professional Preparedness

Training emerged as a recurrent issue across the literature. Ipinnimo et al. (2025) found that 66.1% of surveyed Nigerian doctors had education or training on breaking bad news and 64.1% were aware of SPIKES. A higher proportion of doctors with education or training fully adhered to SPIKES at the bivariate level, although training

did not remain an independent predictor after regression adjustment (Ipinnimo et al., 2025). Okoye et al. (2024) likewise reported that Nigerian oncologists needed communication training. These findings suggest that some doctors acquire disclosure skills informally, but informal learning alone may not ensure consistency, ethical sensitivity, or reflective practice.

The need for training is consistent with international literature. Baile et al. (2000) introduced SPIKES as a six-step protocol for delivering bad news in oncology, while Rosenzweig (2012) emphasized that breaking bad news is a patient-centered communication task requiring appropriate setting, understandable language, emotional assessment, and a transition from diagnosis toward realistic planning. In Nigeria, training should include not only SPIKES but also role-play, simulation with standardized patients, feedback, reflective debriefing, language adaptation, family-conference management, spiritual sensitivity, and strategies for communicating under time pressure.

Facility Type, Workload, and Health-System Constraints

Health-system constraints are not merely background factors; they actively shape communication. Ipinnimo et al. (2025) found that doctors in public tertiary and public secondary/primary health facilities were less likely to report full SPIKES adherence than doctors in private facilities. The authors linked this disparity to workload, patient volume, time pressure, and limited resources in public healthcare settings (Ipinnimo et al., 2025). Okoye et al. (2024) similarly found that clinical workload affected the capacity of Nigerian oncologists to break bad news. Ibrahim et al. (2012), writing on disclosure in sub-Saharan Africa, highlighted contextual barriers such as poverty, delayed presentation, out-of-pocket care, cultural and religious explanations, fear of angry relatives, concerns about litigation or reputation, lack of formal training, overcrowded hospitals, and resource limitations.

These findings imply that individual communication skills are necessary but insufficient. A doctor cannot consistently provide patient-focused disclosure if the clinic lacks privacy, if dozens of patients are waiting, if no trained interpreter is available, if there is no referral pathway, or if the doctor fears violence after a death notification. Institutions must therefore treat adverse diagnosis communication as a quality-of-care process requiring operational support.

Religion, Spirituality, and Meaning-Making

Religion and spirituality are important dimensions of Nigerian illness experience. Ipinnimo et al. (2025) found that a small subset of doctors used religious or spiritual approaches when breaking bad news. The presence of spiritual language in disclosure does not automatically undermine patient-centered care; it may provide comfort when aligned with the patient's beliefs. However, spiritual framing becomes problematic if it replaces diagnostic clarity, discourages informed decision-making, or imposes the doctor's beliefs on the patient.

Patient-focused practice should therefore distinguish between patient-led spiritual support and clinician-imposed spiritual explanation. A doctor may appropriately ask whether the patient would like spiritual or family support, whether a chaplain, imam, pastor, or trusted relative should be invited, or whether prayer is meaningful to the patient. The doctor should not use religion to avoid honest disclosure, minimize prognosis, or shift responsibility away from clinical explanation. This balanced approach respects Nigerian cultural realities while preserving autonomy and truthfulness.

Language, Health Literacy, and Diagnostic Understanding

Nigeria's linguistic diversity and unequal health literacy create additional challenges. Patient-focused disclosure requires that the doctor assess the patient's preferred language, avoid unexplained biomedical jargon, use short information segments, check understanding, and invite questions. The Knowledge component of SPIKES was the most highly reported in Ipinnimo et al. (2025), but information giving is not identical to understanding. A patient may hear the diagnosis but misunderstand its severity, treatment implications, or urgency.

A patient-focused medical officer should therefore use plain language and teach-back. For example, after explaining a cancer diagnosis, the doctor might say: "I want to be sure I explained this clearly. Can you tell me what you understand about what we have discussed?" This shifts the burden from the patient's intelligence to the

doctor's clarity. In hierarchical contexts, such wording is preferable to "Do you understand?" because patients may answer affirmatively to avoid appearing disrespectful.

Discussion

The synthesis shows that patient-focused adverse diagnosis communication in Nigeria is an emerging but uneven practice. Nigerian doctors appear increasingly aware of structured disclosure protocols, and many report using SPIKES or elements of it. Yet the evidence also shows persistent gaps in invitation, patient autonomy, communication depth, empathy, workload support, and training. These gaps are not unique to Nigeria, but they take distinctive forms within Nigerian sociocultural and health-system realities.

The most important finding is that patient-focused communication is both an interpersonal and institutional practice. At the interpersonal level, the medical officer must prepare, speak clearly, assess patient preferences, respond to emotion, involve family appropriately, and provide next steps. At the institutional level, hospitals must create space, time, policies, supervision, and referral pathways that make such communication possible. Without institutional support, patient-centered ideals may become unrealistic expectations placed on already overstretched clinicians.

The relatively lower adherence to the Invitation step in the Nigerian SPIKES study deserves particular attention. Invitation is ethically important because it operationalizes respect for patient preferences. Some patients want complete information immediately; others prefer staged disclosure; some want a trusted relative present; others may initially avoid details but later request them. In family-oriented cultures, doctors may assume that relatives should receive information first, but patient-focused practice requires that the patient's own preference be elicited whenever the patient has decision-making capacity. The question is not whether family should be involved, but how family involvement can support rather than displace the patient.

The evidence on power relations further suggests that patient-focused disclosure requires deliberate communication behaviors that redistribute conversational space. These include open-ended questions, pauses, reflective listening, checking understanding, acknowledging emotion, and asking permission before discussing prognosis. Such behaviors may appear simple, but they challenge entrenched patterns in which doctors speak and patients listen. Medical education should therefore treat communication not as personality-based kindness but as a clinical competence that can be taught, observed, assessed, and improved.

The RESPECT-NG Framework for Nigerian Adverse Diagnosis Communication

Based on the synthesis, this article proposes RESPECT-NG, a six-domain framework for Nigerian medical officers conveying adverse diagnoses. The framework builds on SPIKES while adapting it to Nigerian clinical realities. It is designed to be memorable, teachable, and flexible across primary care, emergency medicine, obstetrics and gynecology, pediatrics, internal medicine, surgery, oncology, and palliative care.

RESPECT-NG domain	Core practice	Nigerian contextual adaptation
R: Readiness and setting	Prepare the facts, choose a private space, sit down where possible, reduce interruptions, and anticipate emotional reactions.	If privacy is limited, use the quietest available space and avoid disclosing life-changing information in open wards unless unavoidable.
E: Explore perception and preference	Ask what the patient understands and how much detail the patient wants at that moment.	Ask whether the patient wants a relative present and identify who should participate without allowing relatives to automatically replace the patient.
S: Share knowledge plainly	Give a warning shot, name the diagnosis, avoid jargon, speak in	Use the patient's preferred language; involve trained

	short segments, and check understanding.	interpreters or reliable language mediators where possible; avoid euphemisms that obscure the diagnosis.
P: Pause for emotion, family, and spiritual meaning	Allow silence, recognize distress, respond empathically, and ask about emotional, family, or spiritual support needs.	Respect religious coping when patient-led, but do not use spiritual language to avoid honest explanation or impose beliefs.
E: Enable decisions and next steps	Discuss treatment options, prognosis where appropriate, costs, referrals, warning signs, and immediate priorities.	Include financial navigation, social support, and realistic discussion of available services because cost and access strongly shape Nigerian care pathways.
C/T-NG: Continuity, team support, and navigation	Summarize, document the discussion, arrange follow-up, involve the multidisciplinary team, and provide contact or referral information.	Use nurses, social workers, patient navigators, palliative care teams, and community supports where available; plan further conversations because disclosure is a process.

The framework's central premise is that adverse diagnosis communication should be understood as a process, not a single announcement. Many patients will not absorb all information during the first conversation. Follow-up encounters should therefore revisit understanding, emotional response, family dynamics, treatment decisions, and practical barriers. This is particularly important when patients must raise funds, travel long distances, consult relatives, or reconcile biomedical advice with religious and cultural interpretations.

Implications for Medical Education

Medical schools and postgraduate training institutions in Nigeria should integrate adverse diagnosis communication into clinical curricula as a longitudinal competence. Training should begin before clinical rotations and continue through housemanship, residency, and continuing professional development. Students and doctors should practice disclosure using simulated scenarios involving cancer, fetal loss, HIV, stroke disability, surgical complications, pediatric poor prognosis, and end-of-life transitions. Assessment should include not only whether the diagnosis was stated, but whether the doctor assessed perception, elicited preference, used understandable language, responded to emotion, involved family appropriately, and provided next steps.

Training should also include reflective practice. Doctors often experience distress, guilt, fear, or emotional exhaustion after difficult disclosures. Okoye et al. (2024) found that Nigerian oncologists experienced the disclosure process as overwhelming, and Ipinnimo et al. (2025) reported that 34.3% of doctors had bad experiences related to breaking bad news. Debriefing and mentorship can help doctors process difficult encounters, learn from mistakes, and reduce avoidance behaviors.

Implications for Hospital Policy and Health-System Governance

Hospitals should develop locally adaptable disclosure policies. Such policies should state that competent adult patients have the right to receive information about their diagnosis and care, while also allowing patients to nominate relatives or request staged disclosure. Policies should discourage routine disclosure to relatives before patients unless the patient lacks capacity, has explicitly requested that arrangement, or emergency circumstances justify it. They should also specify documentation standards, interpreter procedures, violence-prevention protocols, and referral pathways for psychosocial or palliative support.

Public facilities require special attention because evidence suggests lower full SPIKES adherence in public settings than in private facilities (Ipinnimo et al., 2025). Improving communication in public facilities may require

protected consultation spaces, clinic-flow redesign, appointment systems, communication checklists, patient navigation, and adequate staffing. These interventions are not luxuries; they are part of safe and dignified care.

Implications for Research

Future Nigerian research should move beyond self-reported adherence and examine observed communication behavior. Self-report studies are valuable but may overestimate patient-centered practice because clinicians often report what they believe is desirable. Audio-recorded consultations, standardized patient assessments, patient-experience surveys, and qualitative interviews with patients and relatives would provide richer evidence. Research should also examine differences by specialty, gender, language, region, facility type, diagnosis, and stage of illness.

There is also a need to study patient preferences directly. Nigerian patients may vary widely in how much information they want, whether they prefer family presence, how they interpret prognosis, and what forms of hope they consider meaningful. Patient-focused communication cannot be fully understood from clinicians' perspectives alone. Future studies should therefore include patients living with cancer, chronic kidney disease, neurological disability, obstetric complications, HIV, sickle cell complications, and terminal illness.

Limitations

This article has limitations. First, it is an integrative narrative review rather than a systematic review or meta-analysis. Its purpose was conceptual synthesis and framework development, not exhaustive evidence quantification. Second, available Nigerian evidence remains limited and often focuses on specific regions, specialties, or professional groups; therefore, findings may not represent all Nigerian geopolitical zones or facility types. Third, several studies relied on self-reported communication practices, which may be affected by recall and social desirability bias. Fourth, because no primary dataset was provided, this article did not present original patient or clinician interview data. The proposed RESPECT-NG framework should therefore be empirically tested and refined through future Nigerian studies.

Conclusion

Patient-focused communication when conveying adverse diagnoses is a crucial but underdeveloped component of quality healthcare in Nigeria. Current evidence suggests that many Nigerian doctors recognize structured disclosure practices and frequently report using SPIKES or related approaches. However, persistent challenges remain, including incomplete elicitation of patient preferences, doctor-centered communication patterns, workload pressure, limited training, variable family involvement, religious meaning-making, language barriers, and weak institutional support. A patient-focused approach should combine truthfulness with compassion, autonomy with family sensitivity, biomedical clarity with cultural humility, and individual skill with system-level support. The proposed RESPECT-NG framework offers a practical starting point for training, policy, and research aimed at improving the dignity, safety, and humanity of adverse diagnosis communication in Nigerian clinical settings.

Declarations

Ethics approval and consent to participate: Not applicable. This article is an integrative narrative review and did not involve human participants or primary data collection.

Consent for publication: Not applicable.

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