Editorial

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Breaking bad news in clinical medicine. Little learned pearls

Dando malas noticias en la clínica médica. Pequeñas perlas aprendidas

Entregando más notícias na clínica médica. Pequenas pérolas aprendidas

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It is usually what we like the most that we choose as a medical specialty and depending on the general characteristics of that clinical specialty we have certain scenarios with different frequency. Clinicians who have frequent contact with cancer, with chronic degenerative diseases in an advanced state, palliative medicine, among others, are frequently involved with the issue of prognosis, quality of life of these chronic conditions, but remarkably intensive care doctors face the difficult task of talking almost daily with family members about the progress of the critical illness of their loved ones, possible clinical scenarios, complications inherent to the disease and the different life support measures applied, the fall into cardiac arrest or the need to escalate treatment and not infrequently about the imminent death of patients, at the same time that they cannot ignore the rest of their responsibilities in the ICU. Delivering bad news in these circumstances is a task that requires multiple professional competencies, serenity, humility, experience, ethics, humanism, intelligence, compassion, empathy, communication skills and to follow certain rules.

The clinical scenario where the doctor gives bad news directly to the critically ill patient is rare, given the usual communication barriers in the ICU, sedation, intubation, delirium, non-invasive ventilation masks, etcetera.

In this same journal, *Carrillo Esper* and collaborators published an article years ago on how to give bad news entitled: *Communicating bad news in the Intensive Care Unit «Primum non nocere»*, where it is highlighted why it can be mutually distressing to give bad news, emphasizing the fact that health personnel in general face the reality of having limited abilities to communicate them, and where the concept

of communication barriers in the physician-patient-family trinomial are discussed,[1] the topic is still important today and currently being instructed in diverse medical schools around the world through different courses as the *Serious Illness Communication Skills Training (SI-CST) course*, generally delivered to advanced undergraduate medical students.[2]

Some authors have tried to create a methodology for this medical activity with a humanistic approach and although appropriate in its general approaches, its specific application in the medical practice in the ICU's is rare probably due to the specific context of the critically ill patient, although it serves as an excellent frame of reference.[3] They described the protocol *SPIKES* focused on the cancer patient (and with a normal state of consciousness) consisting of six steps. The goal is to enable the clinician to fulfill what the authors consider the four most significant objectives of the interview disclosing bad news: gathering information from the patient, transmitting the medical information, providing support to the patient, and stimulating the patient's collaboration in developing a strategy or future treatment plan; there is an updated protocol version based on identification of daily clinical needs and pedagogical challenges.[4] There are also some other approaches aimed at identifying and exploring emotional cues and using nonverbal and verbal ways to respond to emotion including the *NURSE* statements, equally focused on cancer patients.[5]

That is why one of the best hospital rotations during the internship to observe and learn these specific skills and abilities among other important aspects of contemporary medicine is precisely the ICU.[6]

There is no particularly favorable time to receive bad news, although fear and uncertainty tend to increase at night; that is why it is worth addressing this point from the beginning, highlighting the fact that the intensity of work in the ICU may trigger the schedule to vary, but that there will be an every day information session, preferably in the morning when the whole picture of the last 24 hours illness evolution is available, as well as the radiological and laboratory results, and let them know that important variations towards deterioration will be communicated immediately, as soon as possible, preferably by the same doctor, although this can sometimes be difficult in large public institutions, while in the private sector it will generally be advisable to have it done by the main treating doctor.

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There are families of very different characteristics, some very receptive, calm and grateful, and at the other extreme, some very large, demanding, aggressive and who question everything. All deserve attention, courtesy and an individualized plan of action by the practitioner offering the information. It is advisable on many occasions to request the designation of a family representative (or two) who will be contacted especially on a daily basis to communicate clinical changes, making them responsible for transmitting the information to the rest of the family.

First, it will be essential to know the case well, master all the details and, of the utmost importance, ascertain the exact name of the patient and its main characteristics. An error in the name, sex, or a large difference in estimating the patient's age can have catastrophic consequences in the communication process at an algid moment, with highly stressed family members; keep in mind what would be a successful outcome of the challenging dialogue you are about to have with your patient's relatives. The objective will always be to preserve a good and virtuous doctor-patient-family relationship.

Over time, when a good relationship with the family is established and if appropriate, the use of the patient's affectionate name can be valued, especially in the extremes of life (the «Baby girl» or «Pacecita», for example may be better received by certain families than grandmother or Mrs. Paz), although this must be assessed on a case-by-case basis, and may even request the family's permission to name the patient that way. We must always show kindness, education and respect.

Before approaching the family, talk to the nurse, and find out the details, observe the monitor and check the hemodynamic and ventilator parameters and alarms, carefully review the ICU table and the file, and still inside the ICU and preferably in the privacy of the patient's room, do a quick mental exercise and review exactly all the important points to communicate prioritizing and numbering them, never improvise, prepare, relax and then proceed to give reports in a logical and organized way; try to visualize what the main concerns, fears and questions will come up in the conversation and be prepared to respond properly on the fly to the family's reaction. The meeting could be awkward, so you need to be sure you have the necessary tools to navigate the situation well; particularly now that we are facing a post-pandemic irritable social mood in the world.

Calculate in advance and later explore what the family expectations are, what do they understand about the acute or acute on chronic morbid process and how much they want to know, during the subsequent sessions this can be considerably refined; clues can be obtained about what a family member wants based on the words and arguments they use. Identify the family leader and what place he or she has in the family and especially with the patient, as well as detect the problematic members of the family, quickly learning everyone's names to always address them appropriately, as a courtesy and respect sign.

Although the use of language has changed in the world, especially in recent years and in our environment, the medical professional will try to address relatives like «*You*», in languages such as Spanish *(Ustedes)*, French *(Vous)* and other romance languages that, unlike English, have different voices for the singular and plural second person, the latter being of the utmost respect, especially the elderly and aggressive, regardless of whether they address the doctor in the singular second person; the use of «Mr.» or «Lady» can be useful, as well as that of university degrees (lawyer, engineer, etcetera).

Preferably use the designated space in each institution to provide the reports and in those where this does not exist, select the best possible place that offers privacy and comfort, if possible, allowing people to take a seat; the corridor or the door of the ICU where many individuals circulate at all hours, it is not a good place.

During the interview, the doctor's physical image is important as well as making eye contact with people. You as physician in charge should be calm, appropriately modulate the volume of your voice, not use technical medical language and not create false hopes, and as far as possible try not to use strong words such as death or cancer and prefer softer ones such as «the end of his/her days» or «the underlying disease» or «main condition». Words have a powerful effect on the modulation of human feelings since we are complex social entities. The human mind processes the information it receives and collects, getting in tune with the environment that surrounds it, that is with the specific situation, irretrievably occurring an incessant process of feedback used to modify and adjust their actions, behaviors and responses, so words of comfort and consolation to the family are of the utmost significance, a kind of useful psychological therapeutic verbal support at the right time to deliver particularly adverse news.

It will be necessary to be very careful when answering percentage survival probabilities, always clarifying the limitations of these figures and that they generally represent averages of populations or scores constructed and validated in similar populations, but with a wide range of variations and that the most difficult thing in acute biological events is to predict outcomes. Don't trade numbers or allow yourself to be cornered by family members who want to hear from you what they want if it leads you away from the truth. It will be of greater benefit to talk with them until they see the situation from

a new perspective through affirmative feedback, and it is clear to them that the medical part understands why they feel that way.

Nonetheless, it will undoubtedly be inappropriate to assume a strategy of superiority or handle the family as kids, always remembering that medicine is a profession of service.

It is essential to comment here that no distinction should ever be made in the practice for communicating news, warmth and the quality of the information for social, cultural, religious or other reasons.

If clear family disagreements surface, remain neutral and exclusively address medical aspects and not sociocultural or economic ones; all patients are equally important and all families deserve the same respect and attention, this must be demonstrated in the daily clinic with facts.

If there are complications, genuinely explain and clarify them in the simplest possible way, without catastrophizing but truthfully, making clear their unintentionality and that they are part of the natural process in the pathophysiology of the disease or in the medical care process, highlighting the importance of having been detected in a timely manner, as well as its solution, this will give them the feeling of being well informed, honestly and will lead to gaining people's trust, significantly improving the doctor-family relationship, whose long-term benefit is extremely important, it is always better to remain on the «conservative optimistic» side.

Offer any assistance you can or refer the family to someone who can offer aid, remember to be sympathetic and understanding of the hard situation, let them know that you recognize those are difficult news to hear, and that you comprehend what they are going through. It can be extremely supportive to just have someone offering sympathy and compassion in hard moments.

Finally, try to involve the family in further planning and decision making if they are open to it, considering always demographical, cultural and religious variables with respect and attention. Relatives tend to better embrace the medical recommendations, after having experienced the sensitive emotional support of their doctor.

Unfortunately, most of us physicians tend to be bad psychologists, but it is never too late to acquire and develop effective communication resources. To the extent that some of these guiding actions and small tips learned over time are implemented within the appropriate context, it will be possible to establish fluid communication and a strong and healthy physician-patient-family relationship for the benefit of all, building a more humane Critical Care Medicine.

REFERENCES

1. Carrillo-Esper R, Contreras-Carreto NA, Remolina-Schlig M et al. Comunicando malas noticias en la Unidad de Terapia Intensiva. "Primum non nocere". *Rev Asoc Mex Med Crit y Ter Int*. 2007;21(4):194-199.
2. Yuen JK, See C, Johnny Cheung KTK, et al. Can teaching serious illness communication skills foster multidimensional empathy? A mixed-methods study. *BMC Med Educ*. 2023;23(1):20-29. doi: 10.1186/s12909-023-04010-z.
3. Baile WF, Buckman R, Lenzi R y cols. SPIKES-A six-step protocol for delivering bad news: Applications to the patients with cancer. *The Oncologist*. 2000;5:302-311.
4. Meitar D, Karniely-Miller O. Twelve tips to manage a breaking bad news process: Using S-P-w-ICE-S - A revised version of the SPIKES protocol. *Med Teacher*. 2022;44(10):1087-1091. doi: 10.1080/0142159X.2021.1928618.
5. Back AL, Arnold RM, Baile WF, et al. Approaching difficult communication tasks in oncology. *CA Cancer J Clin*. 2005;55(3):164-177. doi: 10.3322/canjclin.55.3.164.
6. Elizalde-González JJ. La importancia de la medicina crítica en el internado de pregrado. *Med Crit*. 2018;32(3):120.

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