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Editorial

The communication of bad news in medicine

La comunicación de malas noticias en medicina

Communicating bad news is inherent to the practice of medicine. A physician may be required to inform patients of unfavorable situations thousands of times during his/her career.[1] The ability to communicate with patients has been wrongly considered as a minor ability as compared to other technical aspects of care.[2] This aspect of the physician-patient relationship is however highly relevant. We therefore think that the ability to adequately communicate bad news to patients and the currently available resources to improve such ability should be part of the knowledge and training of physicians.

Various population surveys suggest that the attitude of patients has changed, and they usually want and expect detailed information about their diseases, potential treatments, and prognosis.[3,4] When information is too terrible for patients, they will develop a number of mechanisms to cushion the effect as much as possible.[3] Good physician-patient communication has been shown to have a positive effect on patient satisfaction with care received, treatment decision, protocol compliance by patients, patient stress, and claims for malpractice.[2] On the other hand, practitioners find the experience of communicating bad news distressing.[5,6] Finally, there is little evidence to show that the difficulty involved in communication of such bad news decreases with age.[7]

Despite the importance of how such bad news is communicated and the frequency with which this should be done in our profession, almost no educational system provides specific training to such effect either before or after graduation.[5-7] There are however a multitude of communication skills that may be learned and will be directly related to some clinical results such as increased patient satisfaction and confidence, improved information exchange, and a greater possibility of taking joint treatment decisions.[2]

There are various definitions of bad news in medicine. Bad news would essentially be that dramatically altering the future prospects of the patient and/or his/her family, causing an emotional disturbance that will persist over time.[6]

Two main tools are available to improve our ability to deliver bad news to patients: protocols and training courses.

The rationale for using protocols for bad news communication is the same as for any other complex act (e.g. cardiopulmonary resuscitation) performed in medicine: division of a procedure into different steps simplifies its conduct. Systematization of the act involves a lower chance of error and greater reassurance for the professional, which should be beneficial for patients. One of the protocols most widely discussed in literature is SPIKES, consisting of six steps and reported by Baile and Buckman in 2000. This six-step procedure is intended to collect information from patients, provide them with information adequate to their needs and wishes, decrease the emotional impact of adverse news on patients and, finally, develop a therapeutic strategy with the active cooperation and participation of patients. The six stages include: 1. *Setting up*: Preparation of interview (review of the case, selection of an adequate environment with sufficient privacy, sitting down, availability of time with no interruptions…), 2. *Perception*: "Before explaining, ask", a principle that will allow for adapting information to each patient. 3. *Invitation:* Find out how much information the patient wants about his/her condition and how this should be given. 4. *Knowledge*: Provide patients with information after warning them that this will not be good news. Terms adequate for their understanding capacity should be used, avoiding technical terms. Doors should not be completely closed; if there are no prospects for cure, ways to control pain or improve symptoms may be discussed… 5. *Emotions:* Response to patient emotions is one of the most difficult challenges when communicating bad news. An attempt should be made with show empathy with the patient.[2] 6. *Strategy and summary*: Patients who have a clear plan for the future experience less anxiety. At this time, the clinician may make patients feel that their wishes are important and

the treatment plan will be jointly decided by both. Moreover, the uneasiness of the professional when reporting adverse prognoses or the need for treatments with severe adverse effects may be decreased if the protocol has been applied.[3]

There are other reported protocols,[8,9] and although there is some agreement between these types of clinical guidelines and the vision of what patients and their families expect when they are told bad news, there is not much evidence of their degree of implementation in clinical practice when they are not associated to training courses. Nevertheless, professionals who work with such guidelines have been reported to experience less stress when communicating bad news.[7]

Training courses for physicians on how bad news should be delivered have been developed in recent years. It is known that the presence of an external observer to evaluate the physician-patient interview may introduce bias and be intimidating.[2] The advent of new technologies has allowed for audio or even video recording of visits to analyze them in greater depth.[2] In addition, various methods have been devised to assess the quality of the dialogue established between physician and patient at the oncology outpatient clinic.[10] All of these have been used for development of training programs. Such programs usually consist of intensive course lasting several days during which the physician is trained in communication techniques using simulated patients.

In any case, it has not been conclusively shown that these findings based on observation may be converted into useful clinical recommendations influencing the care of patients.[2] Most results of these courses are based on surveys completed by participants about their degree of self-confidence when faced with this type of interview before and after the course. This type of assessment provides little evidence about the effectiveness of these courses for translation of skills acquired into clinical practice and for improving patient-related results.[7] It has however been shown in randomized trials to be effective for improving the communication skills of oncologists, and persistence of such improvement was found at 12 months even if no additional activities had been carried out for the same purpose.[11,12] Other authors reported the need for support training after the initial course.[13] It may be concluded that courses of this type, although expensive and time-consuming, are necessary.[7]

In our setting, training received for communicating bad news would mainly be based on our own experience and on the experience of our "masters" as seen by us. The recommendations I have found to be useful for me and my residents over years of care practice would include:

- Smile and be kind
- Provide a sensation of proximity (also physical, by holding a hand, etc.)
- Take adequate time to explain and understand
- A patient given bad news is in shock and does not understand you. Give him a new appointment at a later time
- Be honest with your explanations, degree of understanding, and the expectations you generate
- Do not close all doors (transmit as much hope as possible)
- Remember that nobody wants to be here, try to be patient

The problem is that in the current context, in which medical acts are based on the available evidence, this learning would translate into a degree of evidence, and consequently of recommendation, which are simply unacceptable. The above listing is no more than a statement of good intentions with no further scientific interest. As if that were not enough, our practices are usually overcrowded, and we have therefore little time available for each patient, patients ("users") and families are more and more informed (Internet, etc.), but also more demanding and unclear (it is not always clear how much information the patient and family want)... So, what should we do? Our duty is to try and provide information as adequately as possible and to have available the necessary tools (protocols and/or courses) for this. It would be useful if our institutions (as already planned by the AEU) helped us in this part of our training.

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