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EDITORIAL

Humanization in the communication of bad news in cancer and palliative patients

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Summary

Although the communication of bad news is a moment of great vulnerability for the patient and his or her relatives, it is necessary for quality care. However, it is a cross-cutting skill that often needs more specific training in medical schools. Numerous protocols lay the groundwork for efficient communication. However, each physician's personal touch makes a difference in terms of humanity. In this article, we reflect on the predominant vision of communicating bad news in the Medical Oncology Service of Fuenlabrada. We expose metaphysical, psychological, and social concepts on which there is a need to reflect to be able to improve from a deep understanding of the difficulty that the communication of bad news entails. Finally, we suggest elements that can be easily incorporated into daily clinical practice.

Keywords:
MeSH: Neoplasms, Mortality, Communication, Health Communication, Interdisciplinary Communication, Palliative Care.

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Introduction

The communication of bad news is a fundamental tool in clinical practice; however, it tends to constitute a skill frequently forgotten by training systems in the health field. It is a difficult skill to perfect, and no formula guarantees efficient and humane communication. However, there are a series of guidelines that help lay the foundations of the communication process and a series of nuances that can be enhanced to take care of the human component.

The concept of dying

Oncologists and palliatives are frequently faced with delivering large-scale lousy news, which often addresses the concept of dying. Death is an increasingly masked notion in Western societies. Parallel to the development of the welfare society, death has ceased to be a natural generational change to become something avoidable. This thinking is related to the wide acceptance of beliefs such as faith in science and its advances or the infallibility of the health system and its professionals. It is also related to the continuous search for immediacy, which in the health field is translated as the aspiration for instantaneous healing [1]. In our society,

death feels like a distant and improbable event. In some medical specialties, such as oncology, the doctor is the person who first breaks the illusion of immortality so socially widespread.

The clash between reality and expectations

The communication of bad news always begins with a clash between clinical reality and the expectations of the patients, which include both the doctor's expectations based on the therapeutic process carried out, as well as the expectations that the patient and their relatives place in the health personnel and the expectations that the patient himself may have about his existence and his future [2].

Breaking these expectations is painful, and the doctor becomes the short carrier of absolute desolation. This desolation will be transferred to the patient and their relatives, emotions coming into play that will make the impact much more significant.

The communication of bad news is an opportunity to care.

Good communication of bad news is a necessary step for quality care. This necessity is because focusing the clinical situation on the reality of the now, even though initially it is a complex emotional blow, will allow subsequent healthcare to be adapted to the real needs of the patient [2]. In addition, although it is one of the most vulnerable moments of the entire clinical process, it is also one of the circumstances where the “art” of caring can be put into practice the most [3]. The acquisition of skills in this more human and less technical aspect of medicine should be a fundamental objective in the development of any health professional.

Discussion

Oncology is a specialty with a fascinating human dimension and lends itself to enhancing the ability to "care" in those who practice it. From experience, the action of "caring" is often something as simple and at the same time as complicated as "knowing how to be".

If we understand the communication of bad news as an "occasion to care," we can easily deduce that the mere fact of transmitting information ("communicating") is not enough but that we must be able to "be" ("accompany") and collect the emotions that this process generates: fears, frustrations, anxieties, questions, denial, guilt, anger and sadness.

In addition, it is essential to learn to "return"[3], to accompany our patients insistently and for a long time to respond, if possible, to the psychological and metaphysical sphere that arises around the end of life and that is as important as the organic sphere [4]. On many occasions, when we do not have answers, simple active listening and showing that we continue to care are of great help to the patient and their families. Accompanying such delicate moments is not just a duty but a privilege.

There are many basic systematized guidelines to learn how to communicate bad news, among others, in the SPIKES protocol (acronym translated into Spanish as EPICEE) that are widely accepted in clinical practice [5]. The SPIKES protocol establishes six fundamental steps for efficient communication of bad news. "S": Social environment, "P": Perception, "I": Invitation, "K": Knowledge, "E": Empathy and emotions, and "S": Strategy [5].

However, the nuances that each doctor gives to this protocol make the difference in the communication process. For this reason, we present below those points that may be useful based on clinical experience.

Regarding the "K" of "Knowledge"

When the doctor communicates terrible news, and even more so if it has to be communicated in terms of possibilities, there is a difficult crossroads between hope and that whoever listens to us knows that they are close to the end of their life and that they are in good health and peace with it. We must not fall into false optimism or catastrophism. The doctor has to look for the middle term: measure the words, dose them, give answers, and respect the times of each person.

At this point in the protocol, it is imperative to adapt the language and avoid technicalities. In addition, the information must be dosed, and concise and clear messages must be sent. The use of circumlocutions helps to smooth over bad news, but not only does it not, but it also increases the risk of misunderstanding. It can lead to increased anxiety for the patient if he feels that relevant information is being missed.

Regarding the "E" of "Empathy and emotions",

During the communication of bad news, an atmosphere of trust should be promoted that favors the expression of emotions. We must train ourselves to recognize them when the patient expresses them directly and when they can be intuited through their body language. It is essential to empathize with emotions and legitimize them.

It does not hurt to have some basic notions of psychology that help to understand the emotion and redirect it if necessary. However, it is often enough to empathize and let the conversation flow.

Among the primary emotions are anxiety, sadness, guilt, and anger. Anxiety responds to an assessment of threat and activates anticipation mechanisms. It is redirected by centering the person in the now [6]. Sadness responds to an assessment of loss where the focus is systematically placed on the negative. It is redirected by expanding the vision to other areas and breaking the selective attention mechanism toward what is harmful [6]. Guilt responds to an assessment of responsibility and triggers rumination mechanisms. Stopping guilt involves analyzing error and responsibility, repairing what can be modified, and having an alternative action plan in case a situation similar to the one that has made us feel guilty occurs again. If, despite the above, the feeling returns, it is necessary to avoid entering the rumination circle again [7]. Anger is the most complex emotion and causes the most negative transference phenomenon [8]. Translates an assessment of damage for which another is held responsible. When anger arises, the focus is placed on the intention of the damage received, which triggers aggressive behavior. It is redirected by redefining the objectives. It must be made to understand that the grievance suffered cannot be changed and, therefore, the objective must be "to be well" instead of doing "justice" (which is what is pursued with aggressive behavior) [8].

Regarding the “E” of “Strategy”:

In all clinical situations, especially when we lose the option of a therapeutic strategy aimed at healing or chronification and the objective becomes symptom control, the concept of "relieve" must be kept in mind.

While it is true that managing emotions empathically and setting therapeutic goals is already relief for many patients, it is possible to go a step further by giving a humane response close to the metaphysical needs that will undoubtedly arise [4].

It is essential to understand the end of life as something natural in the history of every human being, to accept our limitations and our lack of control over when it comes and to whom it comes, to open a time of introspection and gratitude for what has already been lived, to understand that each person leaves a unique and marvelous mark on the world, and to contribute to making the last days a time to strengthen human relationships with loved ones, an opportunity to close pending issues, and help find peace.

It is not an easy terrain, and it is not a terrain that all patients will allow us or want to tackle. Nevertheless, with those who open the door for us, if we find the right words, we will be perfecting the "art" of caring and undoubtedly becoming bearers of relief.

Conclusion

Doctors never get used to delivering bad news or the suffering that surrounds death. This lack of confusion is natural, and so it should be. The mistake is to prevent sadness or mourning from arising because they are intrinsic reactions to the process of breaking expectations. Nor should the communication of bad news be understood as a passive process in which information is allowed to flow, and emotions bounce out of control and harm us all. The great success is the training to perfect this process, seeking not only to transmit information but also to "care" through it, being able to empathize and, from there, accompany and alleviate. These values are part of our commitment to preserving the dignity of our patients in the process of getting sick and dying, being good doctors as good as we can, and, above all, being good human beings.

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Abbreviations

SPIKES: "S": Social environment, "P": Perception, "I": Invitation, "K": Knowledge, "E": Empathy and emotions, "S": Strategy.

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