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COMUNICAÇÃO DE NOTÍCIAS DIFÍCEIS: PERCEPÇÃO DE MÉDICOS QUE ATUAM EM ONCOLOGIA

COMMUNICATION OF BAD NEWS: PERCEPTION OF PHYSICIANS WORKING IN ONCOLOGY

COMUNICACIÓN DE NOTICIAS DIFÍCILES: LA PERCEPCIÓN DE LOS MÉDICOS QUE TRABAJAN EN ONCOLOGÍA

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RESUMO

Objetivo: conhecer a prática de médicos que atuam em oncologia na comunicação de notícias difíceis, identificando estratégias e dificuldades em realizá-la. **Método:** qualitativo descritivo, realizada com quinze médicos que atuam em oncologia. Os dados foram coletados por meio de entrevista com roteiro semiestruturado elaborado pelos autores. **Resultados:** notou-se que, paradoxalmente ao contexto da humanização na atenção à saúde, o processo de ensino e aprendizagem tem desprezado pilares da atenção humanizada. Notou-se a insipiência do conhecimento sobre comunicação de notícias difíceis juntamente com a carência de disciplinas que abordam o tema durante a graduação médica. **Conclusão:** para o enfrentamento de situações adversas como a comunicação de notícias difíceis não existe uma capacitação apta a resolver totalmente os sentimentos negativos envolvidos nesse processo. Reafirma-se a necessidade da implantação de estratégias educacionais que caminhem em direção a uma formação médica sincronizada com o processo de humanização da assistência à saúde e com os fatores psicossociais que envolvem o tema da morte.

Descritores: Comunicação; Relações médico-paciente; Educação Médica; Ética

ABSTRACT

Objective: to know the practice of physicians working in oncology on the communication of bad news, identifying strategies and difficulties in accomplishing it. **Method:** qualitative descriptive study performed with fifteen physicians working in oncology. We collected the data by means of an interview through semi-structured script prepared by the authors. **Results:** we noted that, paradoxically to the context of humanization in health care, the teaching and learning process has neglected pillars of humanized care. There is incipient knowledge about the communication of bad news, and lack of disciplines that approach this topic during medical training. **Conclusion:** in order to deal with adverse situations, such as the communication of bad news, there is no training available to fully resolve the negative feelings involved in this process. We reaffirm the need to implement educational strategies that move towards a medical education synchronized with the humanization process of health care and with the psychosocial factors that involve death.

Descriptors: Communication; Physician-patient relations; Education, medical; Ethics

RESUMEN

Objetivo: conocer la práctica de médicos que actúan en oncología sobre la comunicación de noticias difíciles, identificando estrategias y dificultades en realizarla. **Método:** cualitativo descriptivo, realizado con quince médicos que actúan en oncología. Los datos fueron recolectados por medio de entrevista con un guion semiestructurado elaborado por los autores. **Resultados:** se notó que, paradójicamente al contexto de la humanización en la atención a la salud, el proceso de enseñanza y aprendizaje ha despreciado pilares de la atención humanizada. Se notó la insipiencia del conocimiento sobre comunicación de noticias difíciles, junto con la carencia de materias que abordan el tema durante la graduación médica. **Conclusión:** para el enfrentamiento de situaciones adversas, como la comunicación de noticias difíciles, no existe una capacitación apta a resolver totalmente los sentimientos negativos involucrados en ese proceso. Se reafirma la necesidad de la implantación de estrategias educativas que caminen hacia una formación médica sincronizada con el proceso de humanización de la asistencia a la salud y con los factores psicosociales que envuelven el tema de la muerte.

Descriptores: Comunicación; Relaciones Médico-Paciente; Educación médica; Ética

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INTRODUCTION

Bad news in the context of end-of-life care are those that drastically and negatively alter the patient's perspective. They include situations that pose a threat to life and to personal, family and social well-being due to the physical and psychosocial repercussions they bring. They are usually related to a serious, chronic illness and without possibility of curative therapy[1].

The act of delivering bad news will probably be present at some point in medical practice. According to the current Code of Medical Ethics, among other tasks, it is up to the physician to communicate diagnoses to the patient, an action that may impose obstacles in the physician-patient relationship and between other professionals in the health team[2]. In this sense, communication is a crucial element in the care for the oncological patient who is out of therapeutic possibilities of being cured, since it works as a tool for the establishment and strengthening of the relationship between the patient and the physician[3].

It is expected that most people, after receiving bad news, have negative feelings. However, this can be accentuated when the news is transmitted in an insensible and disorganized manner[1]. Less than 25% of the scientific publications on how to communicate bad news are based on original studies and that the resident physicians generally do not have the necessary competence in transmitting it to the patients[4,5]. However, empowering residents and academics to develop skills to communicate bad news can reduce this gap in professional practice[5].

Thus, the present study is mainly justified by the possibility of complementing the targeting of protocols related to the communication of bad news in health care. For this, the evaluation of physicians is justified by the fact that it is the main profession ethically responsible for this task, specifically, when referring to the medical diagnosis. In view of the above, the present study had as objective to know the practice of physicians working in oncology on the communication of bad news, identifying strategies and difficulties in performing it.

METHODS

This is a qualitative descriptive study that seeks to know the perception of the medical professional regarding the communication of bad news to oncological patients and their relatives.

As a descriptive qualitative research, the work consisted of describing characteristics of a given population and phenomenon and establishing relationships between variables obtained through data collection, aiming to understand phenomena focused on perception, intuition and subjectivity in the context of human relations[6].

The research was conducted at a cancer unit of a large hospital located in the expanded health region of the Center-West of Minas Gerais. This service has 17 beds, of which 13 are reserved for SUS. This health region has an estimated population of 438,297 according to DATASUS in 2012[7].

The participants were fifteen physicians working in that oncology unit who have the role of diagnosing, among other situations, the impossibility of cure and referring patients to Palliative Care. Physicians regulated by the law of professional practice No. 12.842, by means of registration with the Regional Medical Council (CRM-MG), were included and those who were on vacation or medical leave were excluded.

Data collection was initiated after evaluation and approval by the Research Ethics Committee (opinion no. 1,234,799) and after participants signed the Informed Consent Form, according to Resolution 466/2012 of the National Health Council (CNS) of the Ministry of Health.

The data were collected through an interview with a semi-structured script developed by the authors with the following guiding questions: "what do you mean by communication of bad news?", "how do you feel about your ability to deliver bad news?", "what are the difficulties encountered in communicating bad news?", "what strategies do you use to communicate bad news?".

The interviews were conducted in a private office designated by the coordination of the service of the described unit, being recorded in a Mp4 device. The audio was later transcribed in its entirety. To ensure the confidentiality of the information, codes were assigned to interviewees (I1, I2, I3...).

For the analysis of the data, we used the content analysis according to Bardin, a method that allows the inference of knowledge regarding the conditions of production and/or reception of the messages[6].

Content analysis consists of three steps[6]:
1- Pre-analysis: selection of the material to be analyzed, resuming the hypotheses and initial objectives of the research, reformulating them in face of the collected material and elaborating indicators for the final interpretation.
2- Exploration of the material: classification and grouping of data, choosing the categories that will command the specification of the themes.
3- Treatment of results obtained and interpretation: organization of raw data, reflecting based on theoretical revision, establishing relationships with reality and deepening the connection of ideas.

RESULTS AND DISCUSSION

Fifteen physicians working in the oncology area were interviewed, with an average of 10 years of professional practice, including clinicians and surgeons. From the analysis of the transcribed speeches, the following categories emerged:

1. The practice of communicating bad news and medical training

The medical practice relies on three types of technology. In a simplified way, "hard technologies" are defined as the equipment used in professional practice; "light-hard technologies" refer to structured knowledge; and "light technologies" are the production of relations between two subjects, basically in what concerns the doctor-patient relationship[8]. In this sense, communication is set as an element of both light-hard technology and light technology, which may include the field of communication of bad news. This ability is tool to establish and strengthen the relationship between the patient in an unfavorable situation and the physician[3]. However, this does not always occur in a satisfactory and effective way. There is a tenuity between the meaning of the expression "light technologies" and the real dimension of the task of communicating bad news. The excerpt from interviewee I1 illustrates this aspect: "what I find difficult is the lack of understanding or when there is a great rejection by the patient to accept what is communicated, [...] when there is a denial from him or from the family, this creates stress in communication." (I1)

The difficulty in crossing the barriers of interpersonal relations and the necessary harmony between the sending and receiving of a message adds up to the complexity of coping with end-of-life situations or the end of the curative process of a particular disease. This can be explained, in part, by the fact that medical training is predominantly based on the biomedical model. In a paradoxical way to the context of humanization in health care, the teaching and learning process has neglected certain pillars of humanized care, insofar as the biological perspective of the biomedical model is imposed in the training process. This is revealed by the lack of disciplines in the curricula of undergraduate medical courses that deal with death, the dying process, and the possibilities in the field of palliative care[1].

Science has assimilated the concept of life very well, but there is a fragility in explaining the concept of death, which is interpreted, in most cases, as a contradictory contraposition of life[9]. This reinforces the trend of training and medical training to focus on "hard technologies", with investment in cure or "non-disease", and the scarcity of investment in tools that make it possible to work on alternatives and focuses beyond the curative process. Interviewee I2's statement reinforces this idea: "I have about five years of practice. I have worked in a very serious specialty with severe cancer patients, and I still have difficulty. I just had a loss that happened on Saturday and it has been difficult even for me to accept the loss of my patient. [...] So, we also need a little more training for that..." (I2)

Other aspects observed in the interviewees' speeches were the superficiality and lack of knowledge about communicating bad news, even though it is not possible to establish parameters for evaluating the real knowledge of this ability. The interviewee's lines and citations mentioned the existence of theoretical constructs and protocols; however, few have talked or detailed them as an integral part and present in their practices: "If I am not mistaken, I have used to guide, at the beginning of my career, an INCA manual on cancer patient approach." (I3) "[...] I also remember having seeing a manual, if I am not mistaken from the Ministry of Health, and I found the approach somewhat superficial and very unspecific". (I4)

The literature offers guides showing how to systematize the communication of bad news, making it less traumatic for the professional and at the same time, focusing attention on the patient. Many authors, since the 1980s, have

sought to summarize the main recommendations for this communication process, most of whom follow a linear approach and are made up of similar steps: preparation for information; communication of the news; and follow-up (emotional feedback, answering questions, evaluating the next steps, ending the consultation)[4]. Since then, there have been several models created, including ABCDE, GUIDE and BREAKS; all having their main elements of communication in common, with some variation in the specific terms used and the sequence of elements[10].

The most commonly used and cited model in the literature, however, is the SPIKES protocol[11]. It is used to guide physicians to communicate bad news, aiming to enable the physician to collect information from patients, transmit medical information, provide patient support, and encourage their collaboration for the development of a treatment strategy or plan. Such protocol addresses basic guidelines, such as professional setting, patient perception, invitation exchange, knowledge, exploring and emphasizing emotions, strategies summary. These are steps to "deliver bad news" in adverse situations, such as deaths, fetal malformation, communication to the oncological patient, family interview for organ harvesting[11]. Some interviewees have mentioned it: "There is the SPIKES, there are theoretical constructs that speak about verbal language, non-verbal language, about communication environment, about the proper manner, schedule, relationship with family, the importance of each of those topics regarding body language, look, touch, interpersonal relationship and how this is built so as to gain the time of assimilation for this patient." (I5) " [...] in these studies, I have also known the SPIKES, which is appropriate for oncology and we have tried to use it in our practice." (I6)

Even with established protocols, most physicians use their experience in clinical practice to decide how to behave when reporting bad news, but it is known that the outcome is not always satisfactory[2]. In this regard, a group of researchers have concluded, through a randomized study with UK oncologists, that more experienced professionals are not necessarily more skillful at dealing with problems relating to communication with their patients. According to researchers of the aforementioned study, communication skills are not acquired over time, but rather with adequate training[12]. This is contrasted in the speeches of the interviewees, making it clear that their actions and feedbacks are guided in professional practice through mistakes and successes or other empirical strategies. The following are the words of respondents I7 and I8: "what I know about difficult communication of bad news is what I have learned on a daily basis, talking to families, seeing how the patient's family reacts on the way it is spoken." (I7) "I do not know of any protocol or scientific method for giving bad news [...]. Unfortunately, sometimes, by seeing what have not worked out and not using it anymore and trying to practice more the way it has worked out." (I8)

The need for strategies to incorporate palliative care into undergraduate curricula is congruent. This can positively impact the attitude of professionals by increasing communication skills and minimizing negative factors in relation to death and dying[13]. This was shown in a Korean study, which revealed that students, after a course on "humanization at the end of life", have improved their communication skills, anxiety and attitudes towards death[14].

A statistically significant difference was observed between professionals with and without previous training in palliative care regarding the knowledge of communication strategies. Professionals with prior palliative training have shown a better performance in this practice as these tend to emphatically appreciate the emotional dimension of care, developing skills that allow them to meet specific demands in the communication process in this context[15].

However, it should be noted that, during professional training, there are few opportunities to reflect on the death of patients and its impact on professional and personal training. Emotional feelings and reactions are repressed, and communication skills, capable of improving interpersonal relationships, remain in the sidelines[15]. In a similar study, among the main factors attributed by the participants, such as those responsible for the difficulties in communicating bad news, the following stand out: the absence of investments for the development of relational and communication skills in medical graduation curricula; the social representations and symbolism of oncological disease; the presence of fantasies related to the

knowledge of the diagnosis and the difficulties to deal with the finitude of life[16].

Moreover, in spite of basic communication skills protocols, interpersonal relationships are complex and need to be taken into account within the understanding of the subjectivities involved. This includes the interaction between the individual, the history, values, culture of the time, and the familiar environment that permeates them[17]. This is addressed by one of the interviewees: "[...] many things, we bring from home: respect, knowing how to listen. This is all part of family background [...]. You cannot teach issues that are more structural, familiar. It is difficult for an adult to deal and change, because there is already a *modus vivendi* already consolidated. But the protocols help us to communicate and end up providing confidence that we do not have to be afraid to communicate, to deliver the news." (I9)

2. Communicating bad news: challenges and strategies

In communicating bad news, health professionals still face significant difficulties regarding the biopsychosocial aspect. Among those expressed by the professionals involved in the communication of bad news, it was highlighted the creation of the doctor-patient bond. In this sense, empathy, respect, attentive listening and no judgments, besides the use of clear and accessible language, are expected characteristics for the full establishment of this relationship[18]. In this context, the ability to understand and use non-verbal language is included as an ability to establish a favorable scenario. The demonstration of empathy and safety through the look, the touch, gestures, body postures and the listening are indispensable subsidies for the establishment of the professional-patient bond in this stage of life, since it allows the patient to express their anguish and fears[3]. With this, the professional bond is built based on praxis, that is, a dialogical interaction between experience and technical-scientific knowledge[18]. Some of the interviewees have demonstrated such ideas: "[...] sometimes it is a more rush situation and we cannot create much effective bond in the first consultation. I find it harder to go on like this. "(I10)" [...] There are theoretical constructs that deal with verbal language, non-verbal language, communication environment, the proper manner, time, relationship with family and the importance of each one of these topics of body language, look, touch and interpersonal relation, that is, how is it constructed so as to gain the time of assimilation for this patient." (I11)

Another issue that was problematic in this category was the difficulty in establishing a harmonious relationship between patient, family and physician regarding the communication of bad news. The revelation of the diagnosis of cancer characterizes an important moment in the life of the patient and family, since it marks the beginning of a series of changes in the daily life of these people. Some physicians provide complete information on the conditions and prognosis of their patients, while others report reasons for not doing so. They justify such conduct as a way to protect patients from psychological distress caused by the disclosure of the diagnosis and also as a way to satisfy the wishes of family members who request the confidentiality of this information[19].

Communication between the physician, family and patient is an important instrument and must be improved to reduce the emotional impact and allow gradual assimilation of the new reality. The objective is to make the conduits more flexible according to the imposed situation[20]. The interviewee I12 explains this problem: "Families often come with that expectation of not telling, not letting the patient know. So I think you have to realize this dynamic, how is the patient inserted in that familiar context." (I12)

Providing more specific information regarding the disease increases the quality of care offered to the patient at the end of life, as they develop a relationship of trust and complicity between them and the physician[21]. In this way, health professionals should be able to perform secure and enlightening communication in order to facilitate the flow of information, adapting communication to the specific needs of each patient within their reality and their way of coping. In addition, it is necessary to involve family members in the process of disclosure and decision making, as they are essential in the context of the patient's relations and their perspectives[19]**.** This was observed and summarized in the interviewee's speech I13: "So, I explain this to the family, that the patient has questions and he wants to know, so we have to answer. Because otherwise he feels cheated, he

loses confidence in you. The bond he has with you, that bond of trust he has with the doctor, he loses, if you try to 'swindle' him, let's say like that. So I answer what he wants to know in a careful, gentle way, and always trying to welcome both the patient and the family." (I13)

Thus, the physician must have sensitivity and insight to respond to what the patient wants to know, without infantilizing, without euphemisms, without trivializing the moment and without withdrawing hope, taking into consideration the level of understanding and the doubts that each patient has[22]. All information must be inserted in the relational process of communication between the physician, the patient and the family, passing by the various stages faced by the patient, from the beginning to the final outcome of the treatment and the illness[16].

Empathy, posed as the ability to experience emotional reactions by observing the experience of others, was another factor elicited in the analysis of the interviews. Interviewee I14 refers to this aspect: "but it is very complicated to put yourself in the other's place because the reality that he lives is different, what he brings from previous history, what he brings of life history, which he brings from family history is very different from what I bring." (I14)

Empathy has had a positive impact from the emotional point of view of the patient and the family. Having an open attitude, being honest, prepared to listen, keeping your word by promoting comfort, consolation and confidence reflect the concept of empathy. In this sense, professionals should seek a good interaction and a change in the paradigm of how they stand before life and its meaning. They should seek the understanding of the pain and suffering of the other, admitting to put in the place of the one who is in unfavorable situation[23]. So the physician needs to be prepared for a contact that evoke his/her own feelings[24]. This can be seen in interviewee I15's speech: "and I often say that the main factor that I use is really trying to have the utmost level of empathy and put yourself in the other's shoes. How would I get that news in that familiar context?." (I15)

In order to put yourself in the other's place, there should be a good dialogue so that the professional can know the family context and the history lived by the patient. By sharing feelings, knowing the patient's life context and properly using good humor, the task of maintaining empathy and hope tends to flow smoothly and suffering is minimized even if there is no curative approach[25].

FINAL THOUGHTS

To deal with adverse situations such as the communication of bad news, there is no training available to fully resolve the negative feelings involved in this process. Evidently, some degree of suffering is present in the patient who receives bad news, and in the professional, before situations of end of life or end of focus of the curative therapy. However, the approach to this theme and the recognition of the complexity that surrounds it constitute as ways of learning to deal with the suffering inherent in the issue of death and dying.

There is the need to implement educational strategies that move towards a medical training synchronized with the humanization process of health care and with the psychosocial factors that involve the theme of death. The current scenario on the process of communicating bad news, as shown in this text, demonstrates the long path to be built by educational institutions in order to guarantee the recognition of the relevance of this theme and its transversality in the context of medical training despite the empirical way certain practices have still been carried out in the health-disease process.

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