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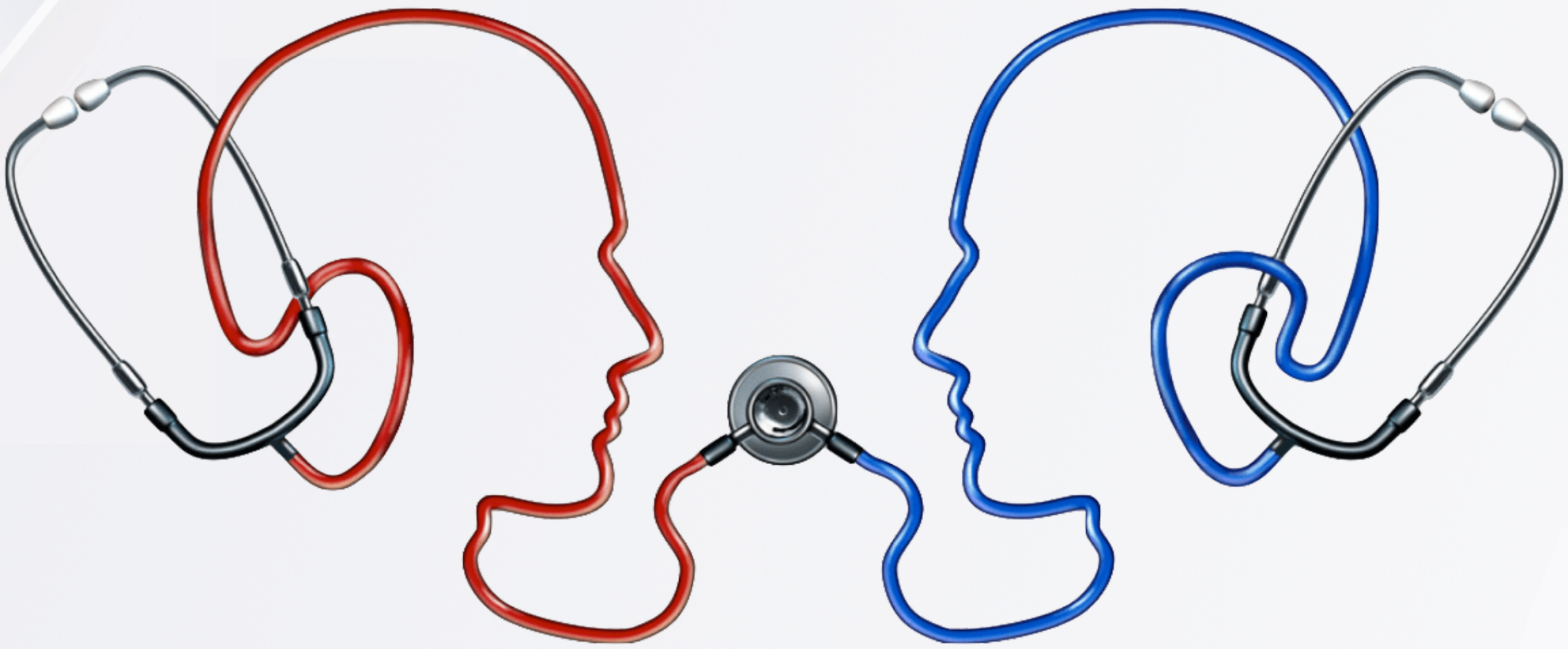

Bad News Communication Protocols

in the Medical Field

Course Support

Erasmus + project: " Bad news communication protocols in the medical field "
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Partners

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- International Institute of Applied Psychology and Human Sciences - Bologna, Italy
- Organization For Promotion Of European Issues (OPEI) - Nicosia, Cyprus
- MEDIJOBS PLATFORM SRL – Bucharest, Romania

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Course Support

Communicating bad news in the medical field

This course material can facilitate your understanding of communication issues in general and healthcare communication in particular.

It is very important how a healthcare professional addresses patients, their families or relatives when they have to communicate a serious diagnosis, serious consequences of an illness or death. Communicating bad news has a two-way connotation. It is deeply emotional both for those who receive it and for the health professionals who deliver it. Therefore, in our course, we aimed to highlight some basic aspects of communication, but also the specifics of communicating bad news in the field, as well as the practical ways in which health professionals can approach this topic.

1. So let's talk about communication

It is a process of exchanging information, ideas, points of view, feelings, etc. between individuals or groups. It can represent symbols, is influenced by cultural aspects, has meaning and maintains a relationship between two or more people. Communication also *represents* something and at the same time *presents* a communication situation.

Symbols may be used in communication between the healthcare professional and the patient or relatives and caregivers, and may be verbal or non-verbal, such as words, logos, pictures, gestures, sounds or anything else that signifies a representation. Sometimes it is preferable for the doctor to use symbols in communicating bad news. In this way the message can be better understood subliminally. For the communication process to take place effectively, symbols and signs must have meaning. They must be related to what is being discussed. For example, the healthcare professional may say "unfortunately the treatment is not working" to convey that it is not working and at the same time make a gesture to show that he or she is sorry - putting the hand over the heart, bowing the head down, etc., to indicate the same thing.

It is very important that verbal lines are accompanied by non-verbal language, so they have an impact on meaning. Imagine a doctor inviting the patient into his office to discuss the results of medical tests that are not good at all by saying "please come in" with a smile or very cheerfully. You would feel anger, fear and that you are alone in the face of tragedy. On the contrary, if the doctor shows you empathy by using a

gesture of touching your hand and speaking to you in a low tone of voice, you will feel that he or she is there for yo

Cultural influence can also manifest itself in a variety of ways: from the greeting, to the distance between interlocutors, to eye contact, to dress, to the way the communication situation unfolds. Of course, a healthcare professional cannot know the general cultural aspects of patients or families, so it is best to pay attention and observe the way the interlocutor interacts.

The place where communication takes place is also important. For example, it is a good idea for the healthcare professional to prepare a specific place to invite the patient or their family to share the bad news. Where they can sit down and be somewhat quiet. Communication is represented by the description of the information, the facts, that the healthcare professional presents to the patient or family. The healthcare professional must bear in mind that the information they communicate is naturally passed through the personal filters of the patients, thus conveying their perspective and vision, thus becoming presentative. Even if they are the same facts, people see them differently.

Communication is like a transaction or "constructing shared meanings or understandings between two or more individuals". Whenever people communicate, there is more going on than the literal exchange of information, there are meanings that arise beyond the content of the message

We think it is useful to introduce you to the components of communication.

1.1. Communication Components

Source

When communicating sad news, the healthcare professional is the source, who designs the message and sends it to the receiver, who is the patient. It is the source sender who encodes the message by choosing the right symbols to convey the desired meaning. By analyzing the receiver's feedback and verbal and nonverbal cues, the source can respond with supporting information or clarification if the receiver did not receive the message properly.

Message

The message is composed of symbols put together to convey meaning. The full dimension of the message also involves nonverbal cues, grammar, style, etc.

Channel

The channel is the medium or way in which the message travels between the source and receiver and often several channels are used at the same time. These can be verbal, written or non-verbal.

Receptor

The receptor is the person for whom the message is intended/addressed.

Feedback

Feedback means responding to the source, whether intentional or unintentional. Feedback is composed of a variety of verbal and non-verbal signals that allow the source to understand how well and accurately the message has been decoded. It is also the means by which the receiver can ask for clarification, express agreement/disagreement, indicate the need for more engaging communication.

Environment

The environment is the space in which messages are sent and received. The environment can influence or indicate whether a discussion is formal/professional or more open and less formal. In the environment in which the message is sent, noise, interruptions can change or block the meaning of the message. That is why it is

particularly important that the doctor or healthcare professional finds a special place that is designated for communicating bad news. Interference can be external, such as car horns, loud music, loud billboards, too hot/cold an environment, etc. that disturbs attention, or internal/psychological. They occur when the thoughts/feelings of both the doctor and the patient disturb attention while communicating. For example, anxiety and sadness that both might feel while communicating bad news.

What healthcare professionals can do when they deliver bad news:

- **Simplifies the message, adjusts it according to the patient or the patient's family**
- **Takes into account the patient/family, their level of knowledge, needs and interests**
- **Actively listens to what the patient/family says**
- **Asks questions and involves the patient/family**
- **Is attentive to their own body language and that of their interlocutors**
- **Maintains eye contact, an indication that they are actively listening and paying attention**
- **Clarifies the message**

1.2. What types of communication are used to communicate bad news?

a) Verbal Communication

It uses verbal language, words, both written and spoken. Preponderance is spoken language. Effective verbal communication relies not only on obvious skills such as speaking correctly and clearly or listening, writing correctly, etc. but also on subtle skills such as the ability to clarify.

How a healthcare professional should talk when communicating bad news to patients/families

- ❖ **Use clear words, as much as possible in the understanding of the interlocutor**
- ❖ **Speak softly and slowly**
- ❖ **Gives the listener time to process what they have heard**
- ❖ **Choose words carefully**
- ❖ **Avoids filler words such as "like", "so", "um", "hmm" etc. Whenever tempted, you can pause**

Active listening is vital for effective communication and improving this skill will help you develop your communication skills.

Thus, it is good for the healthcare professional to focus on the interlocutor, not on what they will have to answer.

Medical staff

- **Use positive reinforcement and encouragement for the patient/family**
- **Words of encouragement**
- **Eye contact**
- **Approval through head movements**
- **Friendly body positions**

Exercise

Play role play. Divide the group of learners into pairs, two by two. One person in the pair plays the role of the healthcare professional and the other person plays the role of the patient/family.

The person playing the medical framework delivers bad news, using the directions that have been covered so far in the course. Then the roles are reversed and continue. Each pair does the demonstration in front of the whole group.

By using the techniques listed, the healthcare professional can ensure that they have understood the message correctly and allow the caller to clarify or elaborate if necessary. Moreover, this behaviour shows interest and respect for what the other person has to say. Questions often go hand in hand with reflection and clarification and are used to gain information. There are two main types of questions that are used when communicating: closed and open.

Closed questions allow the healthcare professional to control the communication and focus the conversation when necessary. They are yes/no question types.

Some examples of closed questions:

- Would you like to know the patient's situation (husband, wife, son, daughter, grandfather, etc.)?
- Do you feel dizzy after hearing the news?

Open-ended questions allow the interlocutor more space for self-expression and facilitate engagement in the conversation, prompting further elaboration and discussion.

Some examples of open questions:

- How did you feel after you heard the bad news?
- What do you think you have to do now?
- How can I help you?
- Who wouldn't hope to become healthy overnight? (rhetorical question that does not require an answer and is most often used to empathise with the patient/family).

b) Communication Non-verbal

It is made up of a wide range of types and categories such as kinesthetic, haptic, proxemics, chronemics, appearance/appearance, artefacts and environment, which become valuable tools for communicating bad news, as these signals can provide additional clues and information vis-a-vis what is expressed verbally.

Elements of non-verbal communication

Aspect

Numerous studies have shown that different colours can evoke different moods. Appearance has the potential to influence both psychological and physical reactions and interpretations.

Gestures are deliberate movements and signals used to communicate meaning without words. The gestures can be:

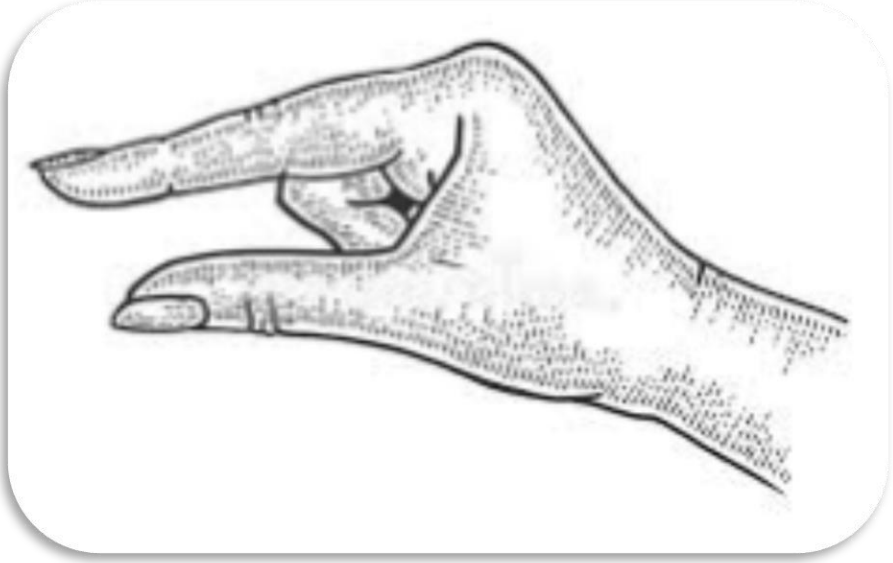
a) *For adaptation* - gestures and touch movements. These gestures can be directed at oneself, other people or objects/artifacts. For example, shaking the legs, repetitively tapping the cap of a pen, rhythmically touching the table with the fingers, etc. are all adaptive gestures that we subconsciously manifest to use up excess energy when we are nervous, anxious, nervous or expectant. Other examples of adaptive gestures can be self-touching gestures, such as stroking or twirling a strand of hair, and these can indicate both discomfort and arousal.

What can be done about adaptive gestures?

- **It is good for the caregiver, when aware that they are making these gestures, to take a few deep abdominal breaths to relieve the tension.**
- **It is also good to touch his neck on the side, where the vagus nerve is, which is responsible for regulating tension.**

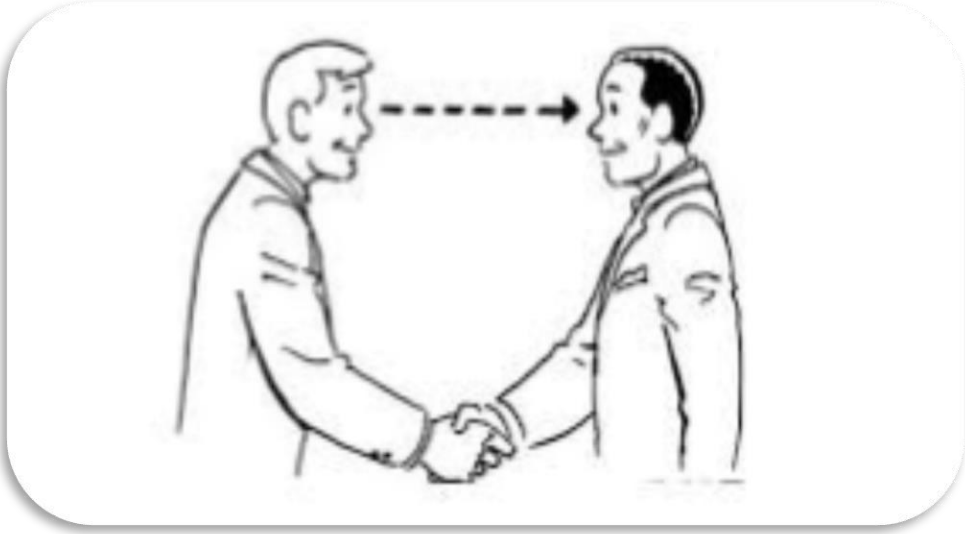
b) *Emblematic* - gestures that have an agreed meaning. The specific meaning may vary according to cultural background or context. For example, a thumbs up means "OK", the same thumbs down means disapproval, something is not right.

c) *Illustrators* - gestures that are used to complement or illustrate a verbal message. The illustrator's gestures are mostly used involuntarily and are manifested naturally. An example of an illustrator is a gesture showing the size of an object.



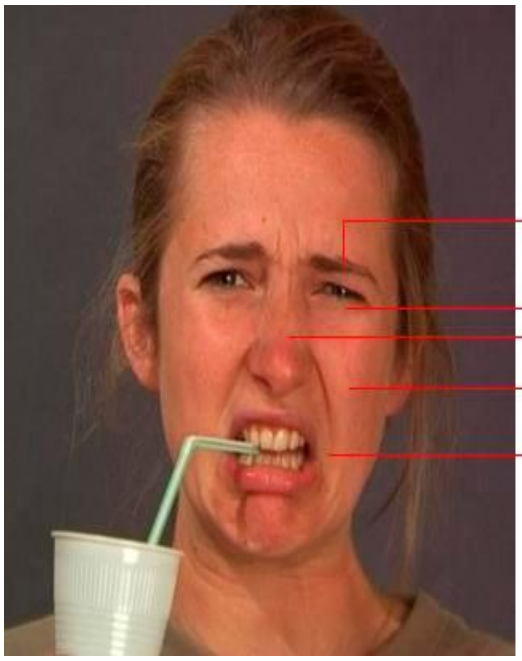
d) *Head movements* are gestures commonly used to convey a variety of emotions and meanings. For example, nodding is a sign of approval, moving the head from left to right signals "no" and tilting the head indicates interest as well as submission and trust.

e) *Eye contact* is an important tool used to communicate, as the face and eyes are generally the focal points during a conversation.



f) *Facial expressions* are extremely relevant as they convey states such as anger, disgust, happiness, sadness, surprise and fear. It is good for the healthcare professional to be able to identify the main genuine emotions.

Joy



Disgust

Contempt

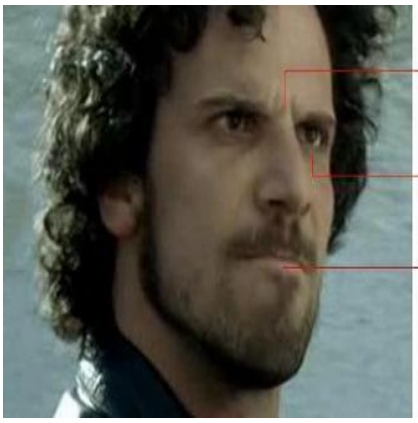
Sprancene ridicate cu tendinta de a se uni

Pleoapa superioara inaltata, pleoapa inferioara incordata

Gura deschisa cu colturile incordate spre exterior

Fear

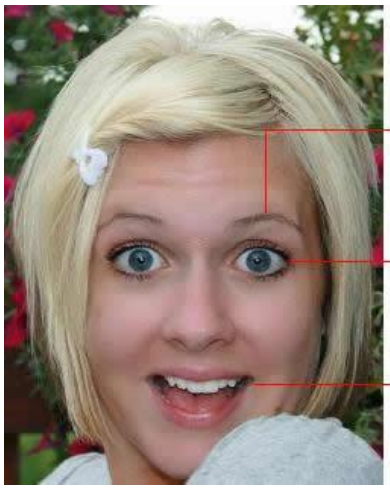
Furies



Sprancene apasate cu tendinta de a se uni in centru

Pleoapa inferioara si superioara tensionate

Buze stranse



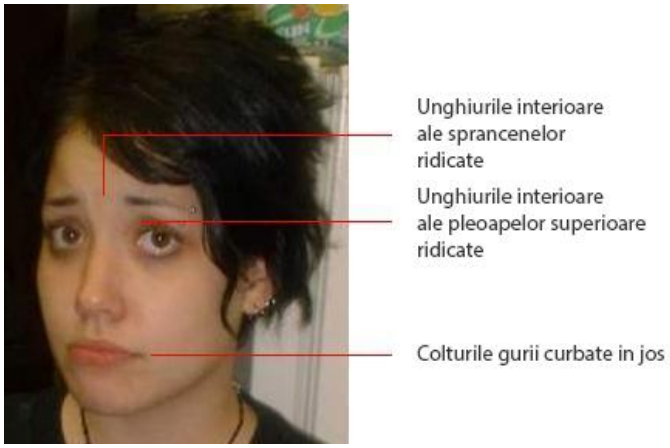
Sprancene ridicate, curbate in sus

Ochii larg deschisi

Gura deschisa

Surprise

Sadness



g) *Haptics* - Haptics refers to communication through touch. It is particularly important for healthcare professionals to use haptics (touch) as an element of non-verbal communication when communicating bad news.

Proxemics

Refers to the space between two people. Intimate space ranges from 1 to 46 cm. This area is generally dedicated to loved ones, family members and close friends and allows for direct physical contact such as hugging, touching.

Intimate space ranges from 1 to 46 cm. This area is generally dedicated to loved ones, family members and close friends and allows for direct physical contact such as hugging, touching.

The social space varies between 1.2 and 3.7 metres and is mainly dedicated to formal conjunctions. Public space ranges from 3.7 to 7.6 m and above and is generally

dedicated to speaking in front of a larger audience, such as in a classroom, auditorium, etc.

Environment.

The environment in which the interaction takes place influences both verbal and non-verbal communication. Medical staff can manipulate the environment in preparation for communicating bad news. Placing objects in a space can help shape the climate of the interaction, from formal or distant to friendly. Also, objects on display can nuance an interaction in equal measure with smell which is often overlooked in the study of communication. For example, think of the smell of "home-cooked" food which most often creates a positive emotional response because it is associated with childhood and lack of worry.

Paralingvistics

Paralinguistics refers to factors such as loudness, tone of voice, inflection, accent pattern or any other vocal elements that are distinct from spoken language.

Artefacts

Artefacts refer to physical objects that can provide clues about an individual's beliefs, ideas and habits. For example, noticing that a person is wearing a Star of David necklace or a Crucifix will tell us about their religious beliefs.

How a healthcare professional can use nonverbal communication

- Be aware of the context in which communication happens, as well as the non-verbal messages they send and receive.
- Be aware that nonverbal cues can complement, enhance or contradict the message. Ensure that the message is consistent across all channels.
- Sending and receiving nonverbal messages, especially touch and personal space, varies greatly depending on context (relationship, culture, etc.).
- To improve decoding skills of nonverbal messages avoid devoting too much attention to a single cue, just eye contact for example.
- Utilizarea indiciilor nonverbale atunci când comunicați veștile proaste, deoarece acest tip de comunicare ajută la exprimări emoționale care au nevoie și oferă sprijin emoțional.

1.3. Informal communication

Informal communication is a multidimensional, relational type of communication that is not bound by specific requirements and does not require pre-defined channels. Informal communication emerges as a natural form of communication, as people interact freely and address a very diverse range of topics. It is the appropriate communication for communicating bad news in healthcare. Informal language may include figures of speech, slang, syntax, etc. It is characterised by simplicity as short or even incomplete sentences are accepted alongside abbreviations or contractions. Informal language allows the expression of empathy and emotion and a personal emotional tone can be detected.

Exercise

- Divide learners into teams of two
- Practice communicating bad news using all the elements of nonverbal communication shown in the course
- Each team shows the group how they communicated using nonverbal language

One way to be effective in communicating bad news is to remove as many communication barriers as possible. So, in the following we will discuss what they mean and how they can be managed.

1.4. Communication barriers

Physical barriers - such as distance, closed doors, material obstacles, etc.

Psychological/emotional barriers - the psychological state of the communicators always has an impact on how the message is sent, received and interpreted.

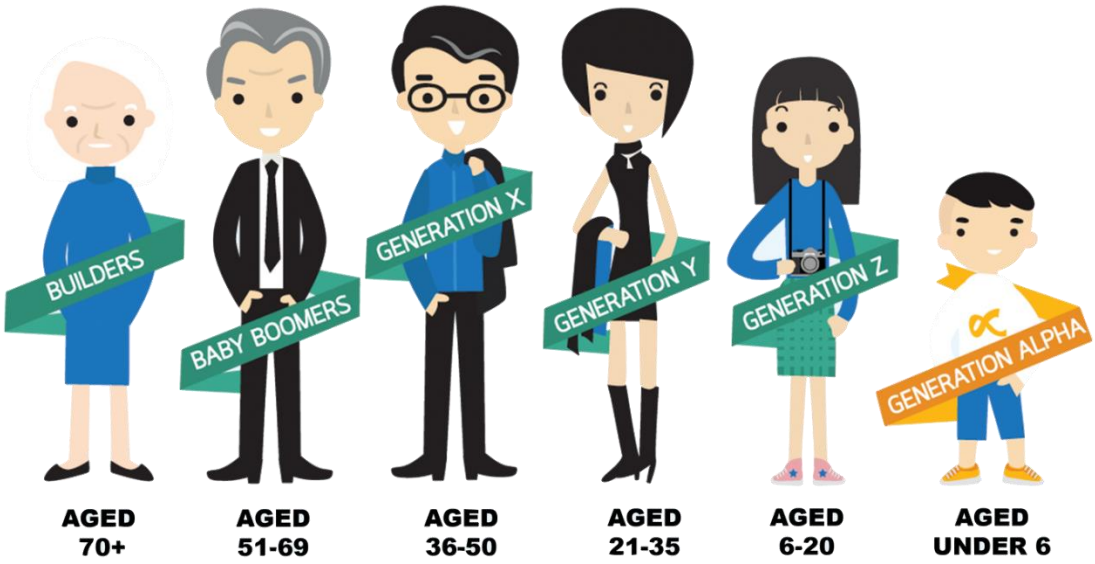
Language barriers - refers to how a person communicates both verbally and non-verbally. These can be related to distractions, lack of attention, different perceptions, physical disabilities such as speech and hearing impairments.

Medical staff

- **Smile,**
- **Nods,**
- **Maintains eye contact**
- **Ask clarifying questions**
- **Encourages patient/family**
- **Uses appropriate language, avoiding specialized medical terms**

It is very important to use constructive feedback. This can improve the relationship and the effectiveness of any further communication. The emotional state of the patient/family receiving the bad news should also be considered.

1.5. Generational differences and communication



In communication it is important to take into account the generation being communicated with, as needs, perceptions and especially attitudes are very different. Thus, we will detail below some generational characteristics and how to communicate effectively.

Generation of Builders - Aged over 70

The best way to communicate with this generation is face-to-face. They expect information to be presented in a logical way and in a clear discourse. The correct use of grammar is very important. They pay attention to how they communicate and prefer formal titles (Mr., Mrs. Doctor, etc.) Respect is essential, for their age and experience. They like to ask questions. They appreciate handwritten notes. They like to answer questions.

The Baby Boomers - Age 51 - 69

It is the first generation to explore electronic communications. They prefer face-to-face, open and direct communication. They have a high availability mentality and attitude. They are less formal than the Builders. They like recognition. They don't mind being called by name without the attribute of ma'am, sir.

Generation X - Age 36 - 50

They tend to be doubtful and cautious, blunt and direct. They prefer to speak short and concise, they don't like to be managed - they don't like overly curious approaches. They care about work-life balance and prefer to have their private time respected. Not interested in recognition, they like digital communication.

The Millennials (Gen Y) - Age 21 - 35

They like to be asked what their preferred method of communication is, they prefer text messages and immediate responses, they prefer short, to-the-point scheduled communication.

Generation Z - age 6 - 20

They are well versed in technology. They listen to and appreciate advice, but like to express their own opinions, they like constant communication. They are less likely to be patient and ask a lot of questions.

Regardless of generation, effective communication is a key element in communicating bad news and can be of great help to the healthcare setting in overcoming communication challenges.

2. The importance of effective communication for bad health news

When it comes to healthcare, effective communication should not be seen as an optional capability, but rather as an essential and integrated part of the medical act, when it comes to delivering bad news, e.g. a serious diagnosis with adverse consequences, a death, consequences of disability following accidents, etc.

The way bad news is delivered can make all the difference to the patient and their close relatives. Overall, the importance of each of these players cannot be undermined, making health-related communication extremely complex. This multi-directional aspect requires healthcare providers to be properly equipped not only to be effective sources, but also to lead interlocutors and help them communicate effectively. In addition to patient-system interaction, healthcare providers at all levels need to be able to communicate effectively with each other to coordinate and deliver appropriate care. If either communication chain is compromised (patient-system or system-system), the quality of healthcare becomes impaired.

2.1. Health and bad news - the importance of diagnosis and prognosis

The main purpose of using bad news communication protocols and techniques is to convey bad news in a way that connects understanding while reducing distress for the patient or relatives. Generally, bad news is associated with a grim diagnosis such as cancer or Alzheimer's disease or death, but the range of bad news is broader than this and can range from telling a patient that they need to take medication for the rest of their life, to telling a patient that they have a low egg count or telling family members to prepare for a decline in the patient's cognitive or motor functions.

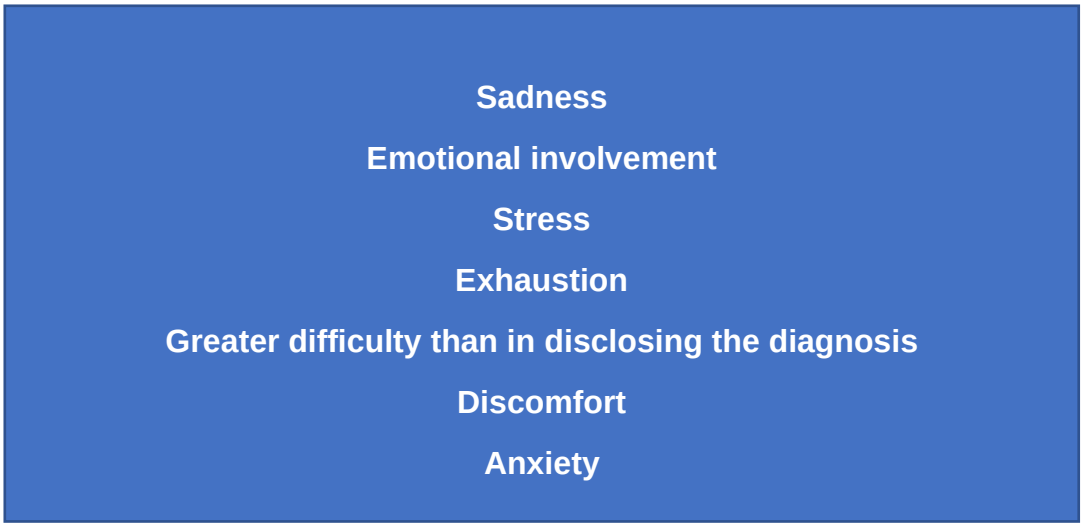
Patients need to understand both diagnosis and prognosis to be involved in medical decision-making and to ensure that their preferences and values are present in treatment and care plans.

The way bad news is communicated matters to:

- **Resilience**
- **Pain control**
- **Emotional health**
- **Blood pressure**
- **Pulse**
- **Blood sugar levels**

2.2. Bad news - the perspective of the medical staff

How health professionals feel when they deliver bad news



The biggest challenges for healthcare professionals when delivering bad news are related to negative emotions, balancing between being clear yet empathetic, selecting the right vocabulary, understanding the patient's personality and personalizing communication, etc. Regardless of years of experience, it is always an unpleasant and unwelcome task. In general, medical training places more emphasis on the biomedical model, while communication skills tend to be given less attention. Because of this, healthcare providers often feel unprepared for the implications and intensity of communicating bad news to patients and their relatives.

2.3. The impact of communication on performance and satisfaction

There is strong evidence that a patient's ability and willingness to follow medical treatment and recommendations, to manage a condition or to adopt a healthy and preventive lifestyle is strongly affected by the communication style and skills of the healthcare provider.

How medical staff communicate bad news

Clearly explains the information
Understands the patient/family/relative experience
Shows patient/relatives that they matter and matter
Provides time and context for the patient/relatives
Encourages patient/relatives
Shows that their patient/relatives' opinions and feelings are respected

2.4. The psychological and physiological impact of bad news

The communication of bad news is unfortunately part of a medical provider's routine and this situation undoubtedly has psychological and physiological repercussions on both the medical provider and the patient.

Physiological responses to bad news for both the patient/patient and the medical staff

- **Increased heart rate**
- **Fluctuations in blood pressure and cardiac output**
- **Increased cortisol level**
- **Weak immune system**
- **Body tremors**
- **Feeling cold**
- **Feeling of "pit in the stomach**
- **Loss of concentration and responsiveness**

Some doctors have said that when they communicate bad news it makes them feel as if they have to change the role of a healer to that of an executioner and for some it has reminded them of their own death and the fact that they cannot control this aspect of life thus making them feel powerless and frustrated. Also, the stress a healer feels in terms of delivering bad news can last from a few hours to over three days. Doctors are highly susceptible to burnout, a condition triggered and heightened by emotional exhaustion, low productivity accompanied by feelings of inadequacy and depersonalisation. These feelings are heightened in those healthcare providers who have insufficient training for such cases.

When it comes to the patient's psychological response, there are a lot of circumstances that influence how they feel and what they experience. Not all patients want to know their diagnosis and prognosis. Patients who receive bad news often perceive the information as too threatening and may deny or downplay the significance of the information. Patients want their doctors to be empathetic, sensitive and understanding of them and how they perceive the potential life changes that the diagnosis may require.

When patients receive too much information that they cannot process, or when they feel there are gaps in the information they receive, they may try to look for it outside the doctor's office by searching the internet or asking around. Many studies have found that such practices can provide misleading, incorrect and inadequate

information that can have significant negative consequences for the patient and the relationship with the doctor and recommended therapy.

What is important for the patient/patient when receiving bad news

Content - clarity, quality of information, comprehension

Facilitation

Support - care, empathy, attention

What patients/patients don't want when they get bad news

- **Not enough time for conversation**
- **Inappropriate physical context (in the hallway, by the door, etc.)**
- **Uncaring behaviour displayed by the healthcare professional when delivering bad news (depersonalised approach)**
- **Lack of attention from the healthcare professional**
- **Use of specific medical terminology**
- **Lack of emotional and cognitive support from the healthcare professional**
- **Lack of direction or facilitation as to what to do next**

3. Communicating bad news effectiveness

3.1. Communication and bad news

From the first meeting with a patient to interventions and the development of a treatment plan, the doctor-patient relationship is built on communication. In the context of bad news, effective communication is not only important to help the patient cope, but it also strengthens the relationship between the patient and the healthcare provider and this has long-lasting positive values in the overall healing process or where healing is not possible, for the patient's quality of life. In general, effective communication of bad news should serve the purpose of forming a solid basis for a constructive partnership between the patient, next of kin and the healthcare team providing care, thereby significantly increasing the chance of appropriate treatment and/or compliance with recommendations.

What to do

- **Communication must be emotionally tailored to serve the cognitive purpose of understanding the patient's emotion (clinical empathy)**
- **Sensitive delivery in a way that fits the circumstances and encourages trust**
- **Active listening and the ability to check patient/relative understanding**
- **Effective questioning skills to elicit the patient's main concerns, perception of issues and very importantly the emotional, social and physical impact on them and their relatives**
- **Provide information using effective explanatory skills tailored to the needs and capabilities of the patient/relatives**
- **Counselling and educating the patient/relatives**
- **Discussing treatment options in a way that helps the patient/relatives fully understand the implications.**

The medical staff to use:

- **Active listening**
- **Nonverbal communication**
- **Stress management**
- **Assertive communication**

Effective communication in healthcare can lead to outcomes such as:

- Improving patient/relative and healthcare provider satisfaction
- Lower risk of burnout for healthcare professionals
- Lower risk of malpractice claims
- Increased disclosure of information from patients/carers
- Increased patient/carer participation in decision-making process
- Increased accuracy of diagnosis
- Better adherence to treatment
- Realistic patient/relative expectations

3.2. Barriers to effective communication of bad news

A major difficulty arises from the fact that the nature of this communication can actually accentuate barriers, and barriers can also negatively affect how information is perceived and digested by the receiver. In addition to the typical communication barriers that apply, communicating bad news in a clinical setting comes with a variety of specific barriers that may be personal, institutional, socio-cultural, training, education level, language issues, etc.

Personal barriers

Differing perceptions - Generally, the transmission of bad news involves a triad consisting of the healthcare provider, the patient and their close relatives. Each member of this triad may have different perceptions of bad news.

Psychological barriers - the person who has to communicate bad news often experiences high intensity emotions such as anxiety, fear of negative evaluation and feels a burden of responsibility that often leads to a reluctance to share bad news. This has been termed the "MUM" effect.

Comfort zone - Delivering bad news can sometimes make the doctor feel powerless or even frustrated. The natural tendency to stay in a comfort zone may cause the doctor to delay or even limit the delivery of bad news.

Healthcare provider fears - Doctors reveal that they often fear being perceived as cold or uncaring by patients and their relatives. Furthermore, they experience discomfort when talking about death and often feel anxious waiting for patient or family reactions to bad news.

Institutional barriers

When it comes to communicating bad news, the institutional limitations mainly relate to the overall organisation and support available to the doctor. Doctors may face time constraints that can affect not only the preparation process for delivering bad news, but also the emotional processing required after the encounter. Another example of an institutional barrier is that it is very rare for the doctor to receive emotional support from colleagues and superiors before and after such an encounter, and this can hamper the doctor's ability to cope with the process.

Institutional barriers

- **Hierarchy**
- **Disruptive behaviour**
- **Generational differences**
- **Gender**
- **Inter- and intraprofessional rivalries**
- **Differences in work schedules and routines**
- **Different levels of training, qualifications and status**
- **Differences in responsibility, pay and rewards**
- **Clinical accountability concerns**

Language barriers

Most commonly, language barriers arise when the healthcare provider and patient do not share a mother tongue, when there is a use of jargon or when too much information is conveyed without the necessary clarification, creating information overload. Understanding the meaning of what is being said can be a challenge if people speak too quickly or use specific vocabulary.

Socio-cultural issues

There is no doubt that a healthcare provider needs to interact with people from extremely diverse socio-cultural backgrounds. An individual's transmitted social behaviour strongly influences the way they communicate, not only in terms of symbols and signs, but also because of different mentalities.

Stereotypes: people tend to rely on oversimplified clichés about individuals from different cultures, ethnicities, social levels, etc.

Etnocentrism: people tend to view other cultures through their own lens.

Conflicting values: sometimes we may feel that other people's behaviour compromises our values or we simply don't agree or understand their behaviour and then culture clashes occur. Some of the common conflicting mindsets/behaviours are:

- preference for direct communication VS indirect communication
- preference for task-oriented VS relationship-oriented interactions
- preference for strong open disagreement VS subtle disagreement
- preference for formal VS informal
- preference for flexibility VS structure
- preference for egalitarianism VS hierarchy

While some people may be natively gifted with better communication skills, there is a big difference between inspiration and training. It is therefore extremely important to understand that lack of proper training can have a detrimental impact that goes far beyond the quality of the medical act itself, but also on the mental well-being of healthcare providers, patients and their families, and not least of all, communication inefficiencies can cause increased financial damage.

3.3. Strategies for improving communication skills

Communicating bad news is a complex process that requires a high level of professionalism and training. The news bearer must be able to convey the message with the appropriate tone and understandable terminology, while assessing the reactions of the patient and relatives. To help individuals improve their communication skills, a number of strategies and models have been developed by researchers to provide inputs for standardised communication designed to ensure effectiveness.

The SPIKES model

The **SPIKES** protocol is a common model for communicating bad news. The acronym stands for **S**etting and Listening, **P**atient Perception, **I**nviting Information, **K**nowledge, **E**xploring Emotions and Empathy and **S**trategy and Summarising.

How medical staff communicate bad news

- **Establish an appropriate framework**
- **Check the patient's perception of the situation that caused the bad news**
- **Determine the amount of information that is known to the patient/relatives and how much information is desired**
- **Know all the medical facts and their implications before initiating communication**
- **Explore emotions raised during the conversation**
- **Respond with empathy**
- **Establish a support strategy**

Steps:

Setting up - this involves preparing the stage for optimal communication by organising the right information, appropriate vocabulary, consistent messaging between all members of the healthcare team. This step also includes preparation in terms of physical space and privacy should always be sought.

The perception - this involves assessing the perception of the patient and their family and how much information they have and very importantly how much they want to know.

The invitation - the patient or family should give permission to have information shared. The medical staff should ask about the extent of understanding and context in which the information fits and then, using the information shared by the patient in terms of understanding the illness, the medical staff provider should ask permission to share information.

Knowledge - delivering bad news should start with a warning statement that allows the patient and close relatives to prepare for the emotional impact. Instead of using technical language, showing patients concrete examples of trends in lab work or radiology can make an abstract concept clearer. The actual sharing of bad news should be done slowly so that the patient and family understand.

Empathy - Receiving bad news can trigger a wide range of emotions for the patient, and the medical provider should make a conscious effort to respond appropriately and with kindness. Empathetic communication should be used throughout the interaction with patients or their families.

Strategy - The final component of the SPIKES model is to clearly establish that patients have a clear plan for the future. It is important to always ensure that the patient understands the information provided to prepare them for active participation in treatment decisions.

The ABCDE Model

The ABCDE protocol focuses on five aspects of the bad news reporting process. Mnemonics mean advanced training, building a therapeutic environment and relationship, communicating well, dealing with patient and family reactions, and assessing the effects of news.

Steps:

Advanced training - carefully review the patient's history, mentally rehearse and emotionally prepare. This stage involves making arrangements for the presence of a support person if the patient wishes this, as well as determining what the patient knows about their condition.

Good communication - avoid technical terms, medical jargon and abbreviations and try to use simple language. Leave pauses and don't rush the patient, but rather move at their pace.

Deal with patient and family reactions - practice active listening, explore feelings and express empathy. Address emotions as they arise.

Evaluate the effects of the news - Clarify and correct misinformation if necessary. Explore what all the information provided means for the patient and loved ones, while being aware of your and your team's emotions.

The REDE Model

The REDE model comes from a conceptual framework that puts the healthcare provider-patient relationship at the centre. It is conceived as an organisation of empirically validated communication skills, which are categorised into three main components of a relationship:

- Establish
- Development
- Engagement
- Relationship

First impressions count. Always try to convey respect and value, because how the scene is set for the conversation matters even if at first glance it is irrelevant to the clinical picture. Make a conscious effort to show that you are responsive and that you see them as a person first and a patient second.

Always try to share the agenda, as patient reactions can be excellent indicators to help you minimize your biases regarding the patient's concerns and priorities and also facilitate partnership.

Introduce technology as a partner. Patients often fail to understand that computers and electronic medical records and documents are an integral part of the medical act and tend to see it as a detractor. It is important to emphasise that the use of technology is a means of improving and facilitating healthcare.

Development - this phase revolves around the growth and evolution of the relationship as a supportive environment is established. It involves getting to know the person better and understanding their clinical picture in a complex biopsychosocial context.

Practice reflective listening in a way that allows you to understand and recognize the intended meaning of your patient's message. This technique has been shown to increase openness, disclosure, and improved communication.

Provoke narrative and perspective. It is common to tend to have a data collection-centric approach during a history interview of the present illness, but it is very important to also try to understand the patient's perspective on symptoms. Try to be curious and explore the psychosocial response to symptoms and the idea of illness as well as the clinical facts.

Engagement - this phase is mainly concerned with the educational and treatment aspects of the patient interaction. Patient engagement improves overall health outcomes by increasing understanding and recall, self-sufficiency and efficacy, and compliance with recommendations.

Don't monologue. In general, there is a large amount of information that the patient receives during a visit to their healthcare provider and they often don't understand or remember a significant amount of it accurately. Try to engage in dialogue and emphasize the importance of the patient's role in their own treatment or health management plan.

Distribute effectively. Simply stating medical facts may not always be enough. Make an effort to frame the information in a context that the patient understands and allow them to ask for clarification.

Provide closure. Try to review the time spent and demonstrate respect and importance and try to reassure the patient that your relationship is an ongoing partnership.

The PEWTER Model

The PEWTER protocol was originally developed as a tool for school counselors, but has been adopted in clinical settings as a framework to help communicate bad

news effectively. Mnemonics stands for Preparation, Assessment, Warning, Warning, Emotional Response and Regrouping.

Steps:

Preparation - this stage is very complex and can be seen as both internal and external. It involves competence in applying communication skills as well as awareness of personal thoughts, values and beliefs. The healthcare provider must consciously understand the role they present in communication and try to shift the paradigm from "the lady bearer" to "guiding a patient's help on a journey to a new stage of life". The view of this role will determine the characteristics of the communication, influence the verbal and non-verbal approach, etc. In terms of external aspects, the physical setting is very important and should be carefully chosen and prepared to ensure confidentiality and limit interruptions, distractions and other potential barriers. This phase also involves reviewing all patient records and available information prior to the appointment and preparing for the appointment in a way that takes into account the patient's context and personal circumstances, timing of the appointment, etc.

Evaluation - this step involves assessing what the patient knows, suspects or understands about the situation. This allows any misinformation to be corrected before the bad news is passed on.

Warning - this is a significant step in the process as it allows the patient to begin processing the fact that bad news is coming. This is normally done by using a verbal structure such as "I'm afraid I have some difficult news to share with you" followed by a pause which allows the patient to have the cognitive and emotional shift and process the idea that something is not right.

Sharing - this is the stage where the healthcare provider shares the news with the patient. This is generally the stage where the healthcare provider experiences the highest level of stress. It is important at this stage to present information in a compassionate manner, use easy to understand vocabulary, avoid technical terms and jargon and very importantly present information in a way that allows you to address the patient and after each piece of information make sure they clearly understand the information being shared.

Emotional response - at this stage stress is at a peak for the patient and they begin to respond emotionally to the news they receive. It is very important for the

healthcare provider to pay attention to this response and assess whether breaks or even another appointment at a different time are needed, as some people can become overwhelmed. At this stage, the healthcare provider can assess whether it may be necessary to involve family members or friends.

Regrouping - this is the final stage of the PEWTER protocol and involves helping the patient determine what steps to take next. In addition to therapeutic guidelines, the healthcare provider should direct the patient to appropriate resources, support groups or additional services that may be helpful in managing the situation. It is important to present information in a way that offers hope without being unrealistic. In less negative scenarios, this may be hope for treatment, hope that the quality of life will not change or that the prognosis is not life-limiting. However, in some contexts, hope may not be obvious and particular attention should be paid to how things are discussed. In these situations, hope should be offered in terms of hope for support, hope for ongoing relationships with the healthcare team, etc.

Kaye's 10-step model

Unlike the models presented above, this model is not a mnemonic approach, but rather a task-centered approach to steps that should be present in any bad news communication encounter.

Steps:

Preparation - this stage involves knowing and understanding all the information about the patient and what they want for the discussion. This step also involves preparing a suitable physical setting, which is private and in which there is sufficient comfortable seating for everyone present. This step also introduces the healthcare provider (if this is the first time they meet).

What does the patient know? - this stage involves finding out how the patient perceives the situation and the facts. This is the time to ask for a narrative of events from the patient or family. Try to use as many open-ended questions as possible, such as "How did it all start?"

More information wanted - at this stage, the healthcare provider can assess how much information the patient wants at that point. This can be done by following

nonverbal cues as well as asking calibration questions such as "Would you like me to explain more about this?"

Give a warning - this is the step that allows you to prepare the patient for the news they are about to receive. This is done by giving a warning statement such as "I'm afraid this sounds serious" or "I'm afraid I have some difficult news to discuss". It is important to always allow a pause for the patient to react.

Allow refusal - at this stage you need to allow the patient to control the amount of information they receive. For some individuals denial is a defence mechanism.

Explain if asked - It is important to provide step-by-step explanations when asked. You need to bridge the information gap in a considerable and empathetic way, whenever after such conversations, the manner in which explanations were given is remembered more accurately than the details themselves.

Listen to concerns - at this stage you need to ask the patient about their feelings and thoughts and give them space to respond, while making them comfortable to express how they feel. You can ask questions such as "What are your concerns right now?".

Encourage debriefing and expressing feelings and acknowledge them - this stage is extremely important for the patient as you can convey consideration and appreciation for the patient and their situation. You can make them feel heard and understood without judgement.

Summary and plan - this is the stage where all concerns should be summarised and addressed, the treatment or disease management plan should be presented and explained and also the stage where hope can be encouraged.

Show readiness - this stage involves acknowledging that future needs and concerns may change and offering readiness for any future communication and assistance to the patient and family.

3.4. Delivering bad news on the phone

Delivering bad news is a difficult task, no matter how many extenuating circumstances there are, and when conversations have to take place over the phone, the challenges are even greater. Particularly during this time when the world is being affected by the COVID 19 pandemic, hospital visits have been massively restricted and many healthcare providers have been asked to communicate sensitive news over the phone more than ever before. In addition, healthcare providers have been challenged to find solutions and ways to keep patients in touch with their loved ones even when their access to medical facilities has been denied.

Steps:

Prepare for the phone call in the same way you would if you were meeting face to face. Make sure you know all the facts and have chosen an environment where the phone conversation can take place in privacy and with as few distractions as possible (do it from your private office rather than the hospital reception or triage area). It is also important to check that the call taker is in the right environment to discuss such news.

Confirm the caller's identity and relationship to the patient and make sure you introduce yourself and your role in relation to the patient.

Warn the patient or relatives and make sure you pause before telling bad news. Use structures such as "I'm afraid I'm calling with some bad news" or "I wish I had better news to give you today" or "I'm sorry, I wish I didn't have to give you this kind of news today". At this point, you may want to suggest that the person sit down for the conversation.

If someone else is present with the caller, offer to talk to them as well or offer to call another person who may be concerned and it is important to repeat exactly the same information to all callers to confirm the message.

Do not end the telephone conversation before the other person has indicated that they are ready to end it.

Make sure the person receiving the bad news has direct contact details for you or a colleague involved in the situation.

After ending the phone call, make sure you inform reception and security staff of the situation and that the family should arrive.

If possible, try to ensure that the family is met by a member of staff on arrival and that they are offered support (formalities, paperwork, etc.).

- **Pay particular attention to your tone of voice.**
- **It is extremely important because you cannot use other elements of non-verbal communication.**
- **Convey bad news with empathy and simplicity and use silence to allow the receiver to process and react to each part of the conversation.**

3.5. Response to patient emotion

It is important to recognise that sensitive or difficult news will trigger emotional responses from patients and their families. While the intensity and type of response can vary greatly - from crying to aggression and beyond - the ability to listen, recognize and respond appropriately to the emotions of your patients and their loved ones is a valuable trait that is essential for a healthcare provider.

A patient or their relative may become defiant for many reasons, such as grief, malaise, substance abuse, fear, anxiety, language difficulties, poor past experiences,

frustration, guilt, etc. These reasons may cause them to be angry, violent, solicitous, threatening, and unwilling to listen and cooperate. Dealing with these reactions requires care, judgement and control, and any deviation can end up making the situation worse. It is important to always remain calm, listen to their message and ask open questions, acknowledging their grievances. Showing a willingness to talk can give the recalcitrant patient the opportunity to state what is causing their anger and understanding this can be very helpful in finding a solution.

Tools for assessing patient emotions

- **low socio-economic status**
- **mental instability problems**
- **employment instability**
- **history of previous violence or destruction of property**
- **diagnosis of mental or personality disorder**
- **substance use disorder**

Factors that increase the risk of violent behaviour

- **substance intoxication**
- **withdrawal from alcohol, opioids or benzodiazepines**
- **psychosis**
- **paranoid delusions**
- **physical agitation**
- **verbal aggression**
- **ineffective pain management**
- **anger**

3.6. Increasing the chances of safety

It is extremely important that a healthcare provider is properly equipped to make decisions that reduce the risk of aggressive and dangerous incidents, thereby increasing the chances of safety. There are a variety of techniques a healthcare provider can use to diffuse a tense situation and disqualify a potentially dangerous situation.

The LEAP framework

One of the basic techniques that are useful in high conflict situations is the LEAP protocol. Mnemonic means Listen, Empathise, Agree and Partner. This protocol is useful when dealing with patients experiencing emotional crises by guiding verbal exchange and intervention. This framework allows you to set boundaries and identify consequences without threatening the patient. Example phrase: "Your behavior makes it difficult to help you. I'd like you to calm down so we can work to make you feel better / and make the pain stop / etc.)".

What to do in the medical setting

- **Verbal intervention and setting the limit**
- **Calm posture and communication in a neutral voice**
- **Avoid arguing and contradicting**
- **Avoid intense eye contact**
- **Keep sufficient and appropriate space between you and the patient/patient's relatives**
- **Validate the patient's concerns and acknowledge their point of view**

3.7. Descaling techniques

As discussed in previous sections, patients and their relatives may experience and exhibit difficult behaviors triggered by chronic and emotional pain, loss, fear, substance withdrawal or addiction, etc. These situations can become not only

extremely unpleasant for health care providers and patients themselves, but can also become dangerous.

The Dix and Page Model

Dix and Page is a cyclical model that comprises three elements that are interdependent: evaluation, communication and tactics. (ACT) The cyclical aspect refers to the fact that each element must be continually reviewed during the application of the method.

Assessment of a patient's or relative's behaviour

- *Situation* - refers to the elements that the patient or relative focuses on just before exhibiting aggressive behaviour
- *Assessment* - refers to the patient's or relative's understanding of the situation
- *Anger* - refers to the emotional response to the assessment
- *Inhibition* - refers to the patient or relative's attitude and general ability to manage aggression
- *Aggression* - refers to the actual behavioural outcome

Maintaining a non-aggressive posture

- Avoiding physical contact with the patient (even if intended as a soothing or gentle touch)
- Avoiding the use of jargon
- Avoiding describing the person who is delivering bad news
- Drawing attention to the impact of the patient's or relative's behaviour

Tactics

- Attitude and behaviour cycle
- The win-lose equation
- Conflict resolution
- Aligning objectives
- Transactional analysis

The Turnbull Model

- legal issues (such as restraint rights)
- theories of aggression
- triggers of aggression
- de-escalation skills
- respect for the patient
- basic control and restraint (such as wrist restraints.)
- advanced control and restraint (such as restraint, relocation, etc.)
- integration of deceleration, control and restraint
- practice guidelines
- incident reporting

Turnbull et al. refers to seven important skills for verbal and non-verbal response to aggression:

- ask colleagues for help
- ask questions about the patient/relative's feelings
- give clear instructions
- maintain friendly eye contact and non-threatening body posture
- be sympathetic and able to separate yourself from the "system"
- show concern
- demonstrate empathy to match the patient's/relative's mood

The Safewards Model

Model elements:

- patient community (patient-patient interaction)
- patient characteristics (symptoms and demographics)
- regulatory framework (legal framework and hospital policy)
- staff team (how staff manage feelings and interact with each other)
- physical environment (hospital layout and comfort)
- outside the hospital environment (what the patient's family and community are like outside the hospital).

- conflict initiation points - situations where aggression might arise as a result of one of the domains of origin.
- patient modifiers - the ways in which patients interact towards each other.
- staff modifiers - how staff manage patients or the environment to reduce conflict.
- conflict - any patient behavior that threatens their own safety or the safety of others.
- containment - ways staff manage conflict, e.g. medication, seclusion, restraint, etc.

What to do in the medical staff

- ❖ **Do not judge**
- ❖ **Be aware of personal space**
- ❖ **Be aware of non-verbal aspects**
- ❖ **Be aware of your own emotions**
- ❖ **Feelings are important**
- ❖ **Defuse challenging questions**
- ❖ **Allow silence**
- ❖ **It is not personal**

4. Conclusions

Bad news is defined as any information that produces a negative effect, a negative consequence in a person's expectations about their present and their future. The fact that communicating is not easy is commonplace to the casual observer. Establishing rapport is not a consequence of some innate skill, but is a skill that can be learned, especially when talking about bad news. Communicating bad news should be added to the training priorities of future doctors in anticipation of generational change. In addition, it is very important to organise an appropriate environment for communicating bad news, so it is necessary to rethink the spaces dedicated to this task in any medical establishment. Last but not least, working in medical units lately involves the integration of multidisciplinary teams and the support of staff experienced in managing emotional overload. Thus, the healthcare professional must be able to do this in the best possible way.