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The communication of bad news in the emergency hospital

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Abstract *The scope of this study was to understand the elements involved in the communication of bad news in the context of medical practice in a Brazilian emergency hospital. It consisted of qualitative research, based on medical anthropology. Data collection was gathered over nine months of participant observation and interviews with 43 physicians. The emic analysis was based on the model of signs, meanings and actions. Two categories emerged from the analysis of the data: bottlenecks in communicating bad news relating to interaction one's own emotions and those of the family member; insufficient academic preparation in addressing death and the impossibility of a cure, with repercussions on professional practice. The difficulties in communicating bad news in the emergency hospital persist and the omission in training has repercussions on professional practice, and the professionals continue to feel ill-prepared. The difficulties are not only technical, didactic or theoretical. Communicating bad news is also permeated by tacit, experiential, relational, emotional, socio-cultural, human, ethical and reflective knowledge.*
Key words *Communication, Emergency hospital service, Medical anthropology*

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Introduction

Over the course of the twentieth century, the profile of medical practice became increasingly biomedical, specialized, technical, and fragmented, focusing on the disease to the detriment of the doctor-patient relationship and the uniqueness of each patient from social, psychological, and communicational perspectives. However, the perception that medical training requires a model of biopsychosocial, ethical, sensitive, and reflective action[1] that considers the determinants and conditions of the health-disease process proposed in the field of public health, which includes communication skills, is recurrent. Communication is assumed to be a dynamic, open, and interactive process[2], intrinsic to the human being[3,5]. This crucial skill in medical practice[3,4] integrates treatment[4] since it is inseparable from the experiences, meanings, and meaningful productions[6]. Therefore, it can generate unpleasant sensations and be a challenging fact for those who receive and for those who communicate bad news[2-5], as it involves psychosocial, emotional, and spiritual aspects of all subjects involved[4,7].

Bad news is understood as information that negatively influences the patient's future[3,5], related to the diagnosis of serious diseases, interference with quality of life, poor prognosis, or death[2-4,7]. Usually, it is up to the physicians to communicate them to patients[3]. Since 1980, practical and didactic protocols have been established to train professionals to communicate bad news, with SPIKES, CLASS, and PACIENTE[3,4,7] being the most frequent in the literature in this regard. However, this topic continues to be recognized as complex, triggering suffering, stress, and anxiety in medical professionals[3,6,7]. Moreover, addressing the communication of bad news is still precarious in the medical curriculum[2,3].

Studies have shown that communicating bad news is not limited to the technique[3,4,7], as it involves welcoming and empathy[3] and demands an interpersonal relationship[4]. Thus, many physicians do not feel prepared to perform this task[3,5], either because they fear not being safe when transmitting information and expressing emotions or because they feel guilty for causing pain or needing to deal with the discomfort of the patients and their families[4]. Research shows that 51% of professionals feel affected by communicating bad news[2].

Therefore, communication is defined as a relational, dynamic, complex, and multidimensional social process whose practice is contextualized in the historical, political, economic, geographical, institutional, and intersubjective spheres[8]. However, publications on the ways this communication occurs have focused on how physicians should act—in terms of procedures, models, protocols, guidelines, and recommendations[9-11]—but do not include the emergency care scenario. There is a lack of studies on physicians' perception of communicating bad news in emergency hospitals[9,12] and the experience of these professionals in communicating it. Moreover, research[6] shows that the aspects involved in this communication have been poorly documented. Therefore, the present study aimed to understand the elements that cross the communication of bad news in medical practice in a Brazilian emergency hospital.

Methodology

This is a qualitative research, anchored in the methodological, theoretical framework of hermeneutic anthropology[13] within medical anthropology[14,15] – an approach that considers the social dimensions and the intersubjective experience in the health-disease phenomenon and distinguishes two inseparable aspects: *disease* – biological process and medical diagnosis – and *illness* – the psychosocial human experience of the disease[15].

This article is part of a larger the ethnographic study entitled: '*Vidas em risco: uma abordagem antropológica sobre as representações da morte entre médicos que trabalham em setores de urgência*' (Lives at Risk: An Anthropological Approach to Representations of Death Among Doctors Working in Emergency Departments – free translation for Brazilian Portguese). It is in accordance with Resolutions No. 466/2012 and No. 510/2016 of the National Health Council (*Conselho Nacional de Saúde*) and was approved by the Ethics Committees of the Federal University of Minas Gerais (*Universidade Federal de Minas Gerais*) and the Hospital Foundation of Minas Gerais (*Fundação Hospitalar de Minas Gerais*).

Data were collected from a large public emergency hospital in Belo Horizonte, Minas Gerais, Brazil. The diversity of medical specialties and the heterogeneity of profiles for critical patients in varied circumstances (acute cases, trauma, accidents, and others) outlined the choice of the institution. The collection of ethnography data lasted nine months, from De-

cember 2012 to August 2013, totaling 864 hours of fieldwork for immersion in the sociocultural universe of the institution's physicians in 12-hour day and 12-hour night shifts, including weekends, holidays, and on specific occasions such as popular demonstrations, the end of a football championship, among others. Participant observation was performed for 24 hours to investigate different contexts.

Data collection was mediated by participant observation and semi-structured guided interviews with volunteer physicians, guests on their shifts and workplace. The main axes included in the interview script were: a) the choice of profession and workplace; b) the dynamics of the unit and challenges in the work process; c) definition of death, preparation, representations, feelings, interests, and relationships in the face of death; d) if it is challenging to give news about sick patients; e) how the profession prepares them to face death; f) if it is challenging to deal with patients who are not curative; g) how they deal with death in the unit they work. Snowball sampling[16] was used to selecting participants, with one interviewee indicating another. Observations were registered in a field diary, and interviews were recorded and transcribed. Data collection was terminated when the quality, quantity, and intensity of the data collected allowed us to evidence the extent of the investigated phenomenon[17].

Data analysis was emic – aimed at understanding the communication of death from the physician's point of view – and guided by the 'signs, meanings, and actions' model[14,18,19]. In this model, practice is the object of study to trace back to the semantic level; it provides a privileged access route to cultural systems. The levels of analysis between each of the signs, meanings, and actions are identified, as well as the relationship between them and their nodal and connection points[18,19].

To ensure anonymity, the interviewees were labeled as F for female and M for male physicians, followed by the interview order, medical specialty, and age.

Results

The study population consisted of 43subjects – 25 male and 18 female physicians, aged between 28 and 69 years – who work in specific units of the emergency hospital for severe patients at risk of death in different contexts, including 23 physicians from the entrance door – operating room, recovery rooms, multiple traumas, and clinical emergencies; 16 physicians from intensive care units – for adults, children, severe burns and extension care services; and four physicians from the progressive care unit, aimed at patients with chronic sequelae. Table 1 shows the characterization of the interviewees.

Table 1. Characterization of the interviewed physicians.

Characteristics	N (%)
Gender	
Female	18 (41.8%)
Male	25 (58.2%)
Age	
28-39 years old	21(48.9%)
40-49 years old	9 (20.9%)
50-59 years old	9 (20.9%)
60-69 years old	4 (9.3%)
Working units	
Emergency Care (surgical room and recovery room, multi-trauma room, clinical emergencies, coordination office)	23 (53.5%)
Intensive Care Units (adult, child, and severe burns)	16 (37.2%)
Progressive Care Unit (chronically sequelae patients)	4 (9.3%)
Medical specialty	
Medical clinic (general and intensive care, Oncology, Nephrology, Cardiology)	20 (46.5%)
Pediatrics (General and Intensive)	4 (9.3%)
Surgery (general surgery, Neurosurgery, cardiovascular surgery, and trauma surgery)	14 (32.5%)
Anesthesia	5 (11.6%)
Years since medical school graduation	
0-9	12 (27.9%)
10-19	13 (30.2%)
20-29	4 (9.3%)
30-39	12 (27.9%)
Physicians unable to inform	2 (4.7%)
Total	43 (100%)

Source: Authors.

Two categories emerged from the data analysis: '*Insertion in medical practice: the challenges of the professional in the communication process*' and *'Main reasons given for the challenges of medical practice: interface with professional education and training.'*

'Insertion in medical practice: the challenges of the professional in the communication process'

This category presents the main bottlenecks presented by the interlocutors related to intersubjective interaction in the professional practice of communicating bad news:

I felt challenged in almost everything, but more in practice. The theory is something we study, but the practice is totally different. When you are in practice, it involves your emotions, the emotions of those you are dealing with, all together with the patient's emotions, and this is something we don't learn. It is life, the day-to-day, that teaches this, such as dealing with your suffering, your sadness, in relation to events, your anxiety (I18, neurosurgery, M, 34 years old).

I missed the approach with the families, the contact with the emergency and urgent care patients. Although we have clinical practice follow-ups in our undergraduate studies, by delivering information to the family and contacting the patient, we are not prepared for these aspects. This is something we learn in our own practice after graduating. Because it's one thing to be present when your preceptor or professor is delivering the news; in those cases, you don't feel responsible for the information. Many times, we learn by observing, but real learning happens when you apply it [communicating bad news] and when you are directly facing the problem. So, everything that we lack practice in, we end up feeling unprepared for (I21, internal medicine, M, 34 years old).

The relationship with family members is sometimes tricky, as the family member tends to deny [the patient's situation]: they rationalize and deny it simultaneously. Sometimes, during the visit, for example, there is a patient in the SAV [intensive care bed for brain death protocol], and you explain that the patient will not walk, will not talk, that only a miracle will allow them to recover. You spend about 20 minutes talking about the severity of the patient's condition. I just don't take away their hope. Some people say, 'Look, my condolences, the patient is dead, we are just completing the tests.' Not me; I like to talk, and at the end of the conversation, after explaining a thousand things, the person asks, 'So, doctor, in a few days, will the patient be going home?' It seems like the relative didn't hear anything you said; they completely deny the patient's condition' (I26, internal medicine, M, 32 years old).

In the reports, it is possible to identify the communication challenges faced by the interlocutors, which are transversal to professional practice, especially when dealing with the emotions of the actors inserted in the dynamics of care (patient, companion, and the professional themselves), the direct relationship with the family member, particularly concerning the transmission of news, including the communication of clinical conditions with a very poor prognosis and cases resulting in death. Communicating someone's death means that the professional 'lost the battle' with it (Field Diary), and it is considered the most difficult activity of their professional practice, leading to a feeling of impotence and an inclination to avoid this moment. The challenges arise from cultural, institutional, and personal issues, such as having to deal with the family's reaction and feeling like failures. After doing so, '*most withdraw, disappear from the area where they work for a while, and only return later*' (Field Diary).

A very common phrase used when delivering news, whether about the clinical condition or death, is: *'We did everything possible*.' This phrase is used especially when there is no favorable prognosis and the patient is either in critical condition or has died. Physicians use it as a way to justify to the family that they utilized all available resources – both technical and human – to try to reverse the situation, but it was not enough to prevent the death.

Sometimes, we face difficulties because we have patients who are not candidates for resuscitation. A patient with such a large (intracerebral) hematoma that draining it is pointless. Cases where the patient 'if they stop [living], they stop,' that's difficult for me to accept. I have resuscitated severely burned patients who were not indicated for it, because you resuscitate them, and the patient stops again later and doesn't come back. It's hard for me to see a patient in cardiac arrest and not be able to resuscitate them because they have no prognosis (I5, anesthesiology, F, 32 years old).

In fact, the phrase '*We did everything possible*' could be extended to '*We did everything possible and impossible*' because, in many cases, doctors, even knowing the irreversibility of the condition, insist on the procedures. Some arguments for this instance were presented as follows:

Often, the family puts a lot of pressure on us as the 'savior,' as if we had that power (I4, anesthesiology, F, 33 years old).

They still hold this romanticized view and think it's a beautiful thing... for example, when the doctor resuscitates a person, they think the doctor can interrupt this course. As if it were something too gratifying, too sublime, too unique, and it is

not [...] Because we work with both situations, there are patients with whom I can intervene concretely, and you determine their favorable prognosis. But it is also common to have patients where you determine the end... that they are going to die, they pass away. If I want the bonus, the credit for having made a positive intervention, I should also accept the burden of a fatal intervention, right? Actually, there is no difference between the two for me, because if I don't allow myself to see it this way, with a certain level of impersonality... (I6, anesthesiology, M, 33 years old).

The patient that we know is going to die is a little more challenging for us because our training is to save them [...]. It is much more frustrating to deal with a person who has a poor prognosis than a patient who is able to survive (I10, general surgery, M, 39 years old).

It's very difficult for me when I am forced to do things with a patient that I would not like to do because sometimes the family does not demonstrate an understanding and ends up forcing the medical team to take certain actions. Sometimes, in dealing with the family, I realize that a colleague did not know how to approach an aspect, and this leads to the decision of an invasive procedure that I do not consider beneficial for the patient. Then I get upset having to carry it out (I27, internal medicine, M, 34 years old).

All these factors mentioned have repercussions on the challenge of communicating bad news:

The patient's family is at the mercy of the doctor. They place supreme power in us (I12, general surgery, M, 64 years old).

From my point of view, it is not ideal, not even close to ideal. Maybe a doctor in an emergency room situation is sometimes very focused on the urgency, on the critical patient, and sometimes gives less importance to delivering news to the family because they know they are trying to save a life. If we stop to think, we see that the person accompanying the patient is very lost, so often, you have to stop, think, and realize that your relationship with the patient's family has to be better. During visiting hours, you are in a room with critically ill patients; sometimes, you are giving news to one family, and another patient is already drawing your attention away. So, the person who is always in this dynamic, I think, fails a little in this relationship (I15, neurosurgery, M, 40 years old).

It is a very difficult relationship because those who come to the emergency room are not in an expected situation; the phone call comes to the person's house saying: oh, something happened to so-and-so. So, the family members are more anxious, the patients are younger, and they are healthy patients. So, it is much more challenging to approach a family, talk about the severity of the case, and tell them that the patient has passed away (I4, anesthesiology, F, 33 years old).

What I find very difficult is delivering the news of a death. I never get used to it; every time a patient dies in our service, I feel distressed about having to deliver the news. So, when the patient dies, we call the family, and they tell me: oh, the patient's family is there waiting for the news. This part is the saddest; it is the worst moment of the medical shift, of medical practice, of our profession. Delivering this news always makes me very upset. When the patient is already very critical, and you have to give the news, the family kind of expects it, but sometimes it happens that the family comes to see the patient, the patient is doing well, the family leaves, and in the middle of the night they get a call to come to the hospital, and when they arrive, you have to tell them that the patient died. This is very difficult, very sad. Death: I introduce myself and say that the patient was very critical, we tried everything, but we couldn't, or the patient was even improving, but there was a complication, the patient went into shock, etc. I use 'passed away,' 'died,' 'did not survive.' Sometimes, you also deliver the news, and the family member faints, screams; I try to comfort the patient (I35, internal medicine, M, 69 years old).

It is worth mentioning that no gender differences were identified; both male and female doctors demonstrated sensitivity and affection in relation to the theme contemplated in the study. In the same direction, the time in the profession (little or much) and the different activity units in the researched universe did not influence the challenge of communicating bad news.

'Main reasons given for the challenges of medical practice: interface with professional education and training'

This analytical category presents the main reasons pointed out by the interlocutors regarding the challenges presented in the previous category (Chart 1).

We noted that medical training is transversal to the main reasons pointed out for challenges with professional practice.

Lack of academic preparation in addressing issues related to the impossibility of cure and death – training is more linked and restricted to the biomedical model: death is an outcome to

Chart 1. Reasons given for the challenges of medical practice.

Subcategories	Excerpts from the interviews
Lack of academic preparation in addressing issues related to the impossibility of cure and death	In college, nobody prepares you to deal with death; in college, they teach you everything you need to do to keep the patient alive until the day your patient dies. Then you have to deal with the first frustration of your life, and, over time, depending on where the doctor works, death becomes part of the routine (I11, General Surgery, M, 39 years old). We see [the approach to] death during our undergraduate studies as a great villain (I3, Anesthesiology, F, 42 years old). We were trained to be the superhero, the savior, the conqueror of death. They never tell you: you are going to lose. You are going to lose many times. They don't teach you that; you learn it the hard way. I missed this preparation for delivering news to families in case of death or disease without prognosis. None of this is explored in academia (I23, Internal Medicine, F, 57 years old). We are trained to prolong life but to deal with death... you notice with the residents that they don't like to stay here [unit for chronically ill patients] because they think: wow, what a boring thing... everyone is dying. So, no one wants to stay in this place, close to death (I32, Internal Medicine, F, 56 years old). I never had the opportunity to observe or simulate delivering death news in college (I19, Neurosurgery, M, 32 years old). I notice that doctors in training are prepared to diagnose and treat. Many times, patients are incurable, so we treat symptoms, provide palliative care, improve quality of life, etc. But, for many doctors, the patient's death is a failure, and sometimes it is not a failure; it is an expected outcome (I14, General Surgery, M, 47 years old). There is no such preparation from an academic standpoint. Schools do not prepare the student, the future doctor, for this [death, impossibility of cure]; it is a matter of day-to-day practice, your residency, your work later as a doctor, as a surgeon; it is something you learn through suffering (I10, General Surgery, M, 39 years old).
Lack of academic preparation – interpersonal relationship (beyond the patient)	There was nothing that addressed the relationship of the doctor with other people. I graduated without understanding that I would be working with people, not just the patient, but also a range of other people I would also be responsible for. Because when I am with a patient, they have siblings, uncles, parents, grandparents, neighbors, friends, and teachers. So, we are not only responsible for the patient; we have to take a few minutes from the shift for these other 'patients' who come along (I37, Pediatrician, F, 58 years old). School teaches us a lot about disease. Life teaches us about the patient. These are two different things: disease and the patient. I have always believed that it is fundamental in medical training to have a foundation to better understand the human being, including the relationship with the family and the patient (I8, General Surgery, F, 58 years old). We have nothing in college regarding contact with the family. No subject prepared you for this. It is much more about science than the human aspect. The human part, the human relationship, is very deficient. I missed that a lot and had to learn it in practice (I28, Intensive Care, F, 49 years old).

it continues

be avoided inordinately, and academic preparation is focused on the maintenance of biological life. The signs' *keep the patient alive*,' '*prepared to prolong life*,' '*prepared to diagnose and treat*,' '*we see death during medical school as a great villain*,' '*prepared to learn to be the superhero, the savior, the winner of death*,' '*doctors in training are prepared to diagnose and treat*' illustrate this perspective.

Lack of academic preparation – interpersonal relationship (beyond the patient). In this subcategory, the interviewees point out the lack of preparation during medical school regarding interpersonal contact, especially with family members.

Lack of academic preparation pertinent to contact with professional practice (communication of bad news, among others). Here, the

Chart 1. Reasons given for the challenges of medical practice.

Subcategories	Excerpts from the interviews
Lack of academic preparation related to contact with professional practice (communication of bad news, among others)	We graduate without adequate practice; you feel totally incomplete (I25, Internal Medicine, F, 56 years old).
	No college class teaches to deliver news; I learned that in practice by accompanying those with experience. So, the student who spends time here in the hospital, for example, we notice that they are interested when we deliver news to someone about death; they want to see how it is, how it is done, how it should be done. Because, in fact, they do not graduate prepared for this, including being prepared to face death. In college, we learn to save lives. Everything we learn there is aimed at keeping the patient alive. Once outside [the college], we try to apply everything we learned there, and we realize that sometimes, no matter how much effort we put in, the patient ends up dying, and many are not prepared for that. Some students and doctors at the beginning of their careers are genuinely very shaken by such situations, to the point that they sometimes cannot cope well with such scenarios (I11, General Surgery, M, 39 years old).
	I missed it. We have a little of this approach in the medical psychology subject. And we see that today›s students really miss this. They come to me, eager to know how to deliver the news to a family member. This is very interesting because it shows that we miss this approach in our undergraduate studies (...). There should be a subject to show what death is, what it means to you, how you can deal with it, how you will deal with family members, so I think there would be no shortage of topics in this approach, and we feel the lack of it keenly (I16, Neurosurgery, M, 32 years old).
	I think it should be a topic better addressed during medical training. I think anthropology [subject] should play a bigger role. It is a subject usually included at the beginning of the curriculum and does not spark much interest in students because they have not yet gone into practice... However, once we are more experienced, we will see the importance of this subject, which should be at the end of school (I2, General Surgery, M, 41 years old).
	The approach to death during undergraduate studies is very limited... You have some subjects [addressing] the doctor-patient relationship, [such as] medical psychology, which covers it a little, but... not necessarily death, so you don›t see that in college. When it does occur, it is at the beginning of the school, and at the beginning, you don›t understand anything... oh, we read that book ‹Sobre a Morte e o Morrer (On Death and Dying)...› you read it and all, but you haven›t yet gone into practice; you don›t know the things they talk about there (I9, General Surgery, F, 38 years old).
	Only after you leave the school do you realize something was missing in terms of contact with practice (...) Whether you like it or not, it›s a reality check because medical students here have a slightly higher socioeconomic level than the patients, and most students here have not had contact with these stories, like the extreme poverty of the patients, lack of education (...) In college, we are trained to pretend when we see all these things. There is societal pressure that medicine is the ‹best profession,› as if we were a resilient wall to handle everything. I saw many cases in college of colleagues who were depressed; there are stories of attempts and actual suicides, drug use (...). The study itself is not that [difficult], but the psychological part is much heavier. Being admitted into the school is hard, but graduating is much harder (I34, Internal Medicine, F, 29 years old).

Source: Authors.

interlocutors indicate the need for practical contact with issues inherent to professional practice. They highlight the lack of preparation for communication, the approach with family members, the doctor-patient relationship, and the application of readings in the fields of anthropology and psychology.

When asked about the death(s) that most marked them throughout their academic and professional trajectory, a specific period of professional training was recalled in most reports:

I was a student, still in clinical internship. There was a patient from the countryside with an undiagnosed disease. He had an enlarged spleen and liver, fever, weight loss, and symptoms we couldn't identify. We ended up admitting him for investigation, and we couldn't discover anything. So, this patient... I was in the internship for three

months and spent about a month and a half with this patient. Then he had to undergo surgery; he went into surgery [feeling] fine but ended up dying on the operating table. This was my first experience with death, and I was devastated because I start thinking: Should he have gone for surgery? The doctors recommended it; I was just a mere student. But then you start to think: What if he were my patient? If I were the responsible clinician, would I have recommended this? You start to dwell on it, wondering where there was a failure, trying to find some sort of fault within yourself as a doctor (I42, internal medicine, F, 28 years old).

I remember many deaths, but perhaps what shaped me the most... Interestingly, I was in the fourth year of medical school, [...] there was an older woman with heart failure. With my student's emotions, I felt I knew more than the doctor caring for her. She died due to insanity [...]. This marked me because the doctor who was caring for her didn't even care. He didn't take care of the patient; I noticed this patient in the ward precisely because of that, because no one was paying attention; she was neglected, and I felt very much affected. I think that shaped me, and I saw that we shouldn't let this happen. Seeing a person die who is being cared for is different. This changed me so much that it has been almost 40 years, and I haven't forgotten (I29, cardiology, M, 63 years old).

I was a student, and I remember an older woman who had heart failure and needed a heart transplant, which is the final treatment for those with this type of disease. And I was very young and saw the difficulty of dealing with our limitations, the impotence of seeing the person getting worse every day and not being able to do anything (I40, internal medicine, M, 29 years old).

Discussion

The interviewed doctors mention the fear of 'losing' the patient, the investment in care, the complex hospital context, the social situation of the family members, and the suffering of those left behind, as well as the gaps in academic training regarding the learning of skills as essential factors in addressing the patient's death and interacting with the family members.

Most recognize flaws in medical training, especially when it comes to the experience of communicating bad news. During medical school, they report having had specific subjects of anthropology and medical psychology at the beginning of the program, when they had not yet started the clinic practice, but at no time is thanatology discussed – which highlights the lack of academic preparation to deal with issues related to patients with severe conditions and with death. Transversal to this is the commitment to two crucial skills for the professional: communication and decision-making. The ability to communicate in the territory of investigation – urgency and emergency hospital – is manifested in several types of news applicable to the professional in this context: announcing the death, informing about the severity of the case and possible chronic sequelae, and communicating to the patient and their family members that there are no longer therapeutic possibilities for a cure. Decision-making, in turn, is intertwined with care outcome in two main points: guilt and, simultaneously, the professional's demand to maintain the patient's biological life.

The data indicate that communicating bad news is frequent and requires a respectful posture of individual and group differences, and it should be directed to each patient and family carefully[7]. In one study, 96% of physicians reported communicating bad news, but 62.2% reported not having training to develop this competence, and only 6.1% rated having good skills for this communication[5]. Diniz et al.[5] showed that 92.5% of physicians face challenges in addressing death with patients and family members, and often, the patient receives bad news without having a companion. Many professionals learn by observing colleagues or by trial and error[5]. Another study indicated that 52.8% of professionals reported challenges in communicating bad news and a lack of academic training on the subject, and 74% were unaware of some method of communication[2]. In addition, the authors found variations regarding age, gender, culture, education, family context, and the disease process that require flexibility from those who communicate the news. Moreover, despite the transformations in pedagogical projects, 38% report that talking about the end of treatment is difficult, and 28% report challenges in communicating death to family members[7]. Physicians reflect on their work and need to deal with the complexity of their feelings[4], including professionals' anxiety[2].

In the present study, the repercussions on the recipients of the bad news also affect the professionals, as there is concern about the emotional and physical reactions and how to manage the situation. In this regard, offering medical training that includes community engagement, where students are integrated into

health services, internships, and residency programs to experience comprehensive care, is crucial. Additionally, students should be placed in environments that allow for emotional expression, fostering a humanized education that develops biopsychosocial and spiritual competencies and skills, considering the sociocultural and epidemiological context[1].

Medical practice, anchored to the biomedical model, attributes to the professional the function of fighting tirelessly for the maintenance of life, even though the impossibility of cure and death itself are recurrent events, especially in the hospital context of urgency and emergency[8]. Such counterpoints make doctors deal daily with situations they were not – and, consequently, are not – prepared to deal with. In many cases, these professionals are anchored to evasive mechanisms to conceal the expression of their emotions throughout professional practice[6].

Throughout the medicine program, the students undergo several experiences that will contribute to shaping their professional profile. One of them is a mandatory curricular internship in service, representing a singular medical training period. Students face more challenging situations because clinical activities take center stage at this program stage, accounting for 80% to 90% of their study hours[20]. Although students lack autonomy in practice and are not directly responsible for care, this stage enhances the development of their responsibilities. There is a greater proximity to challenging experiences inherent to the practice of medicine, especially through daily contact with the patient, their families, and the boundaries of life and death. The students will encounter complex experiences, such as diagnosing incurable or potentially lethal conditions, facing patients deaths, communicating bad news, making decisions about therapeutic approaches, and dealing with pressures from multiple actors involved in the care dynamics (professionals, patients, families), as well as from managers and healthcare systems[20]. The literature indicates that, throughout the internship, professionals improve in the process of communicating bad news, but still face difficulties in developing relational aspects and dealing with emotions[7]. In this learning scenario, the students can understand that they, as future health professionals, should not – and cannot – suffer either.

It is worth mentioning that, in 2014, the National Curriculum Guidelines (*Diretrizes Curriculares Nacionais* – DCN) for medicine programs were reformulated. Among the main guidelines, the teaching of active methodologies that train critical and reflective professionals stands out. The pedagogical project should center on the students as active subjects throughout the learning process and the teachers as facilitators and mediators. Educational institutions must propose strategies for students to develop skills and attitudes to deal with real-life situations, problems, and complexities[21]. In this perspective, medical training is based on competencies. According to Epstein and Hundert[22], competence refers to a set of elements that involve cognitive, interpersonal, affective, emotional, and moral aspects, capable of improvement and evolution through praxis, action, and reflection.

These proposals for changes in the teaching and training of future professionals reflect the need to develop strategies that meet the new complexities of the medical profession and society as a whole. In addition to acquiring technical skills, professionals need to develop skills related to effective communication, organization, teamwork, and professionalism[23,24].

The insufficiency in the training of interpersonal and psychosocial skills[25] and in the communication of bad news[10,25-27] is revealed in a recurring communication model in healthcare that is predominantly informational and unidirectional[8]. Training in communication skills can be useful; however, few studies demonstrate their effectiveness, as they usually evaluate the change in the behavior of medical students, but not necessarily their reflexes on patients[28].

The act of communicating is intersubjective, constituted by interlocutors embedded in a given context, and fundamental in the field of healthcare[8]. Although frequent, communication of bad news in the emergency hospitals is complex and embarrassing because the doctor, touched by their human dimension, expresses reactions and emotions that should be hidden in this environment[6]. Therefore, the intersubjective relationship with patients and families must be improved in the emergency context. In this setting, communication is often superficial, quick, and confusing, challenged by the lack of time and adequate space for communication, especially when confronted by other emergency demands[6].

Moreover, the institutional context of fighting against death, the working conditions with professional overload, the lack of prior knowledge about the patient and their family, the death circumstances, a biomedical education

with gaps in interpersonal and communication skills, and the predominantly technical role contribute to the professional's discomfort in communicating bad news. This is because they are affected by the emotional reaction of the other person and by their expectations regarding the treatment. Therefore, the challenge is not related to conveying technical information but rather to the interaction and intersubjective encounter with the other person, dealing with psychosocial and cultural aspects[6].

Communicating bad news is still challenging due to the impact on those who receive it, the feeling of failure of the professional who transmits it due to the impossibility of saving lives, and dealing with their feelings in the face of death. This lack of preparation and the patient's perception of a lack of skill also highlight the need for strategies to help reduce fear, insecurity, and anguish in communicating bad news, to better handle the boundaries between life and death, and to manage both the other person's and one's own subjectivity[5]. Although fundamental, the proper delivery of bad news is still lacking in healthcare services[5], which should ensure an interpersonal relationship between the narrator and the recipient of the news. This appropriate communication is a right and is essential for understanding the content of the information, whether it pertains to the diagnosis, treatment, care strategies, health promotion, or respect for each patient[4].

As evidenced by the interlocutors, researchers acknowledge that these difficulties in communicating bad news can stem from academic training that still places little value on communication skills, humanized care, and establishing a bond with patients and their families[4]. Protocols have been created precisely to establish a better bond and, above all, efficient, empathetic, and respectful communication with patients and their families[4]. However, practical training in bad news communication is still rare, and simply delivering the news does not equate to qualified communication[3]. Ethical and humanistic principles are required for the reception and integrated care of the patient[4].

The hegemonic training model is anchored in the biomedical paradigm, focusing on disease from a biological perspective, and is technicist, generalizing, and mechanistic[29]. Death is still viewed objectively as a technical problem regulated by the physician, underestimating other psychosocial, cultural, and spiritual aspects[26,29]. It is not a subject of study in medical school[28,30]. When addressed, it is done so in a reductionist manner, as something to be avoided at all costs, associated with professional incompetence rather than the impossibility of cure[25,26].

Thus, despite curricula moving toward implementing training in the communication of bad news and encouraging the inclusion of communication training in the medical curriculum, the focus remains on curative measures, and the

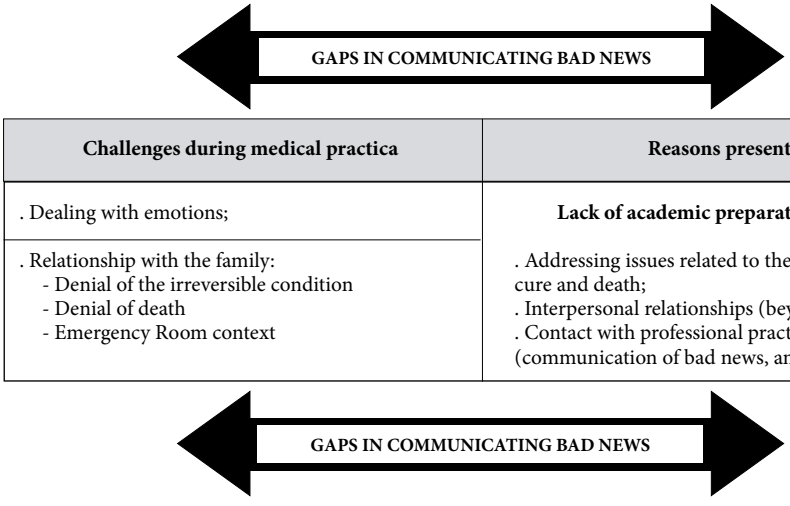

Figure 1. Summary of interlocutors' perspectives.

Source: Authors.

space to reflect on the loss of patients is incipient. The predominant approach still emphasizes the triumph of life over disease and views death as a failure. As a result, psychological issues, death, and verbal and non-verbal communication skills are given little consideration throughout academic training[2]. Therefore, medical education still requires improvement aimed at quality of service, humanization, and care[2]. Figure 1 summarizes the interlocutors' perspectives.

We observed that the gap in training impacts professional practice. Professionals have reported that the difficulties persist, and they continue to feel emotionally unprepared to communicate bad news[7], aligning with our findings. Therefore, feelings, attitudes, self-awareness, relational skills, connection, empathy, and comprehensive care must be addressed[7]. Medical education has been focused on the maintenance of life, and the communication of bad news has not been presented as a possibility of medical care[2,6,7]. The transformations of the DCN for the medical school are still very recent to impact professional practice. The present research indicates that the majority of professionals believe that the learning of bad news communication remains insufficient, highlighting the existing gap in academic training and the need for these issues to be addressed also in other daily professional actions, with the creation of reflective groups, the review of standard operating procedures, and the provision of continuous education actions parallel to the reformulation of basic education.

In the present study, professionals criticized the teaching methods employed, the Flexnerian curricula that dichotomize health and disease phenomena, and point to the need for the teacher to be a learning agent, guide, and facilitator of students' protagonism. In this scenario, knowledge is not only didactic and theoretical; it is also tacit, experiential, relational, emotional, sociocultural, ethical, reflective, and human in dealing with one's own subjectivity and that of others.

Collaborations

GA Souza worked on the conception and design of the article, on the analysis and interpretation of the data, and on the writing of the article; JS Aredes worked on the conception of the project, collection and interpretation of the data, and on the writing of the article; KC Giacomin worked on the conception and design of the article, on the writing of the article, and on the final approval of the version to be published. JOA Firmo worked on the conception and design of the article, and on the final approval of the version to be published.

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