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Delivering Bad News: Should Physicians Express their Emotions?

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Introduction

The traditionally assumed medical dictum is that a physician who expresses his or her emotions in font of patients or their families is almost deemed unprofessional. This feeling may be common place, particularly among traditional physicians who still hold the belief that professionalism is endangered if physicians deliver bad news laced with their true emotions. Discussion of this important topic surfaces now and then and are then hidden away without definite answers possibly due to lack of attention by physician's fraternity to dispense with this out-of-date dictum. Though we understand the protection of professionalism is the basis for this practice, the topic is rarely revisited because the community of physicians remains distant from this sensitive issue, in spite of its importance in achieving high care satisfaction from patients and their families. In view of the increased emphasis on enhancing patients' hospital experiences and satisfaction, the demonstration of sensitivity on the part of physicians in some form as a component of their compassionate care may require renewed attention.

Some Evidences

A literature search on this topic reveals a considerably significant body of knowledge that is mostly based on observation or opinions or on case reports with very few structured empirical studies.

A study [1] on pediatric patients showed that physician empathy, availability, treating the patient as an individual, body language, thoroughness, going beyond the call of duty, accountability and willingness to accept being questioned are the qualities that are considered important by patient's parents during difficult conversations. Another study [2] of patient preferences for the delivery of bad news revealed that patients who were dissatisfied commented on the unsympathetic or pessimistic manner of the doctor. An experimental investigation [3] showed that skillful use of implicit language is a solution to the dilemma of honest but not harsh communication of bad news. The poor doctor-patient communication skills may lead to psychological distress including increased anxiety and depression and poor psychological adjustment to cancer. Presenting 'bad' news in an unhurried, honest, balanced and empathic fashion has been shown to produce greater satisfaction with communication of the news [4]. Additionally, when delivering bad news; physicians should assess the patient's emotional state, readiness to engage in the discussion, and level of understanding of the condition. Often, multiple visits are needed [5]. The Pollak and et al. [6] reported that female patients seen by female oncologists had the most empathic opportunities. Younger oncologists and those who rated their orientation as more socioemotional than technical were more likely to respond with empathic statements. An article based on case studies covering inpatient experience of a physician [7] supports the expression of emotions in inpatient settings in which good rapport with patients and their families are established.

Though these studies are very sketchy and limited, the literature shows diverging evidence/opinions regarding how to communicate bad news. Furthermore, these studies/opinions have limitations including small numbers, small sample size, and an observational nature or are case reports that do not represent a wide range of patients with varied socioeconomic backgrounds.

A Case of Delivering Bad News

A 55-year-old male was recently admitted to the ICU with out-of-hospital cardiac arrest and subsequent 25 minutes of CPR in the field by EMS. Despite multidisciplinary efforts, the patient progressed to brain death by the fourth day of his hospitalization. After confirming brain death, a family meeting was arranged to deliver this bad news in a closed meeting room. I had started by talking about the patient's initial condition, but immediately my words started drowning with sadness. I had to pause for a minute before I composed myself and delivered the message about the patient's brain death. Subsequently, there was silence in the room for a while. After allowing ample time for the family members to express their emotions, I stood up from my chair and hugged all of the family members. Later, the patient's mother spoke up, "Doc we appreciate your care and my son was in great hands, but the God had a different plan for him." After these comforting words, I offered them a prayer service before life support was withdrawn. The mother and family members readily agreed and gathered around the patient's bed to perform their last ritual. After praying, the patient's brother left the room and held my right hand and said, "Doc your frequent communication, coordination of efforts of different specialists and your ability to answer our concerns has made a significant difference during this difficult time. Above all, we are all touched by your caring nature." These comments by the patient's family clearly indicated the impact of timely actions that are of pivotally important for achieving high care satisfaction. I believe that offering the prayer service to the family members provide spiritual closure with the dying and may have reduced their burden of grief. This type of service may also make the family feel good about the services provided by the hospital. Finally, I felt good about the

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care that I provided. I had never felt I was losing my professionalism when I became emotional- this was triggered by flash-back of a scene of a patient's 12-year-old daughter who had come that morning to see her dad and had been inconsolable.

Remodeling Physician-Patient Interaction Paradigm

With the advent of quality of care ratings by the Center for Medicare and Medicaid Services, Leapfrog group and other agencies, the traditional patient-physician interaction model has been expanded with the inclusion of components of patient experience (physician communication and care environment), care efficiency and outcome. Quality care provision entails the interplay of the hospital environmental factors (hospital experience), patient factors (medical conditions and socio-economic factors) and physician related factors, including their cultural background, medical knowledge, attitude and caring skills. Given the current complex nature of the patient-physician interaction model, the adoption of sensitivity by physicians to deliver bad news may be desirable and it may not display one's weakness when care is rendered. On the contrary, the insensitivity of communicating the bad message may be equated with poor patient care. A good bedside manner, addressing daily patient/patient's family concerns, daily communication with the patient's family regarding the care plan and lab/imaging studies/medications are part and parcel of good quality care.

Discussion and Conclusion

The conflicting opinions about expression of emotions by medical professionals must be viewed in the context of current care model that demand enhancement of patient experience. The health care system or traditional medical dictum which dehumanizes the expression of emotions by medical professionals is out of time and is not in line with the current need. We need to understand the display of our emotions/compassion will not diminish or question our capacity to be competent and professional. We must bring our mind and heart to our patient encounters. Medical professionals may have to broaden the horizons of their thinking to support the open expression of compassion to patients and their families. Nevertheless, displaying intense emotions all occasions and the act of self-suffering of physicians after the delivery of bad news may cause burn-out and could interfere with daily performance. Furthermore, it may not be therapeutic in a situation when a family is already in deep sorrow with heighten level of sadness requiring someone else to console them. Nevertheless, the physicians remaining numb to every delivery of bad news may be viewed as 'unprofessional.' This may also constitute bad bed side manner.

Additionally, physicians are not robots who deliver messages without feelings. There is no need for physicians to be tearful openly; however, a mere modulation of tones and facial expressions would do the job. The delivery of bad news embedded with our feelings is valid and needs to be accepted and adopted as our new discovered medical value system. This type of delivery has to be promoted widely among the medical fraternity. The expression of sensitivity may be in the form of words, facial or body gestures or in the form of actions such as frequent visits to the patient's room to assure families about patient comfort, touching ailing patients, hugging family members or patients, offering prayer services to dying patients to allow family members to have a proper closure with their loved once, and others.

If the culture of medicine and health care is to change, we need more people who are willing to accept expression of our heartfelt emotion is important. The emotional connection that we form with our patients is what makes us better professionals.

The emotions laced delivery of bad news is 'professional,' and any attempts to undermine this action may be deemed 'unprofessional.' Why is it so wrong to act like a human being? Being human is important as being professional. It is time to think of changing our professional culture to embrace the truth.

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