



Editorial

How to Speak to Patients



“But for what end, then, has this world been formed?” said Candide.

‘To plague us to death,’ answered Martin.
Voltaire. Candide

Despite unrealistic expectations from people and media, humans are still going to die. For instance despite the improvement in pharmacologic management of Chronic Obstructive Pulmonary Disease (COPD), in home long term oxygen therapy and non invasive ventilation, mortality due to this disease is still high.^{1,2} In addition, the COVID-19 pandemic has warned citizens of high income countries about the persistent unpleasant possibility that humans may die while inducing delay in management of “common” respiratory diseases, thus leading to increase in mortality.^{3,4} However, interestingly enough the large majority of people does not have advance directives and the majority of them never discussed with the relatives about the issue. Nevertheless the notice on a relative’s death is still difficult to swallow, it is a “bad news”: “any news that negatively changes the patient’s view of future”.^{5,6}

What is clear is the way that this news is transmitted has profound effects. It is long remembered and can have a profound effect on the patients and/their families. There is no doubt also that giving bad news also has a profound effect on the clinicians delivering the news, particularly, inducing stress due to that uncomfortable situation. On the other side, a coordinate advance care planning improves end of life care, but also reduces the anxiety and depression in relatives and, most important, clinicians.⁷

Are we, as doctors able to bring the bad news? Communication with patients/relatives is crucial for compliance and adherence with home respiratory therapies.⁸ However, communication is difficult as there is no teaching at most universities and must target individuals often unaware of their diseases. This is especially true for respiratory diseases: a survey of people with COPD reported that knowledge of cholesterol levels and blood pressure was greater than of FEV₁ (if ever assessed. . .).⁹

One more challenge is due to the powerful influence of media on knowledge and perception about health care with quality of information on real possibility of medicine often questionable.¹⁰ For instance, newspapers reported more frequently results of less than high quality scientific studies.¹¹ This has been clear in the recent anti-vaccination campaign on social media by No-Vax people/politicians during the COVID-19 pandemic.¹² Indeed it has been shown that fictions and TV series may also give unrealistic expectations about the prognosis of a disease or an acute event.¹³ Not to speak of these extreme circumstances, a good patient/clinician communication is crucial to make patients follow the suggested regimen (undergoing unpleasant tests such as colonoscopy, etc.,

taking medication properly,¹⁴ practice healthy but uncomfortable life style).

There is an even more (for the doctors) interesting motivation to improve communication skills. Bad communication can be a reason for legal actions against them. Relations and communication with physicians—and eventually dissatisfaction—also have a major role.^{15,16} Dissatisfaction may result from poor patient–physician relationships and/or inadequate communication.¹⁷

Another important issue to consider when discussing with patients/relatives is prognosis. Are we sure to give accurate prediction about survival? A study reported that when evaluating the prognosis of terminal people, only 20% of “expert” doctor’s predictions were accurate, whereas 63% were overoptimistic and 17% overpessimistic.¹⁸ This may lead to unnecessary desperation or disappointment.

How to improve our communication skills

With few exceptions, neither medical students nor residents are taught communication: to be optimistic skills are learned from watching seniors and teachers, to be realistic, each doctor will learn by her/his professional life, at his/her own and/or patients’ expenses.

We need to realize that building up a good communication requires several items, that cannot be mutually exclusive like: **Competence** (what teachers measure in exams), **Compassion** (we are not machines), **Communication skill** (it is not enough to feel compassion for patients – it is possible to feel compassionate towards a patient and yet say the wrong thing) and **Conscientiousness** (it is not enough to be competent, caring and communicative if you don’t work hard for the patient’s well being). Some **protocols** can be used:

The **SPIKES** protocol¹⁹ involves 6 steps: **S**-SETTING up interview; **P**-Assessing the Patient’s PERCEPTION; **I**-Obtaining patient’s INVITATION; **K**-Giving KNOWLEDGE and information to the patient; **E**-Addressing the Patient’s EMOTIONS with Emphatic Responses; **S**-STRATEGY AND SUMMARY. Other protocols like the ABCDE⁵ have been proposed.

However, this standardized Anglo-Saxon style approach may be not suitable to other populations. For example a Latino student attending the Harvard Medical School, Class 2007 wrote as a comment at the end of the course “*I hoped there would be a protocol to follow when a patient dies that would protect me from the suffering and grief. My experiences throughout this course (Harvard ethical course) have proven to me that to have answers to these questions would make me nonhuman*”.²⁰

Some tips how to communicate may be however quite easy to learn. For example effective door-to-door salespersons are trained to build relationships quickly, make customers feel comfortable and being persuasive facing different “subset” of clients. They are trained to be good listener, persuasive, overcame the objections and organized to keep track of the prospect.

Clinicians are not “good listener”, since it has been shown that they usually speak for more than 50% of the time of a talk with a patient, and therefore this latter satisfaction is quite low.²¹ This may lead to poor understanding of disease severity and prognosis especially in people affected by chronic disorders.²² We may also use some “implicit” vocabulary rather than explicit ones, that may further confuse the interlocutor.²³ The diagnosis should be clear and eventually written on a piece of paper so that it can be kept, as well as the treatment options, including palliative care, if desired: the patients has the right to know the prognosis and they should be reassured to have all our support. To be persuasive, the clinicians should first find out how much their patients want to know, since a consistent subset of individuals are reluctant to speak about this issue.²⁴ Indeed we need to understand the basis of communication: the patient has the right to understand what we say and, even more important, they should retain the information for a period of time sufficient to take a decision.

Some very practical issues need also to be kept in mind, for example a private location should be chosen for a talk (external interruptions such as mobile phone must be avoided), scheduling in advance to allow enough time for the talk, inviting a relative if patient agrees. Behavioural sciences also suggest to sit down on a chair or on the edge of the bed at the same eye level and eventually touch the arm of the patient. In other words we need to convince our interlocutors that we are there only for them and are on their side.

In conclusion, breaking bad news is one of a physicians' most difficult duties, yet medical education typically offers little formal preparation for this task. Without proper training, the discomfort and uncertainty associated with breaking bad news may lead physicians to emotionally disconnection from their patients. Focused training in communication skills and techniques to facilitate breaking bad news has been demonstrated to improve patient satisfaction and physician comfort.

“His hands were doing the water-flowing 21-form of tai chi. His eyes were wide open. I was holding in my arms the person I loved the most in the world, and talking to him as he died. His heart stopped. He wasn't afraid. I had gotten to walk with him to the end of the world. Life – so beautiful, painful and dazzling – does not get better than that. And death? I believe that the purpose of death is the release of love. At the moment, I have only the greatest happiness and I am so proud of the way he lived and died, of his incredible power and grace. I'm sure he will come to me in my dreams and will seem to be alive again. And I am suddenly standing here by myself stunned and grateful. How strange, exciting and miraculous that we can change each other so much, love each other so much through our words and music and our real lives.

(Laurie Anderson, Rolling Stone's Lou Reed tribute issue, November 2013).

Conflict of interests

The authors state that they have no conflict of interests.

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