

Delivering Bad News to End-Stage Children: Emphasizing the Role of Emotions

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 [10.30699/jogcr.8.3.306](https://doi.org/10.30699/jogcr.8.3.306)

Received: 2023/03/27; Accepted: 2023/05/02; Published Online: 23 May 2023;

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Dear Editor in Chief

This letter comes to you in the hope of stressing the need to understand age differences and relevant requirements in delivering bad news to end-stage children. Among variables affecting the way healthcare providers communicate bad news, the age of the recipient is a critical factor requiring caregivers' meticulous tactfulness. For practical purposes, various strategies are already suggested for communicating unexpectedly bad news to patients abruptly taken to face their end of life (1). However, patients of different ages may require different strategies. For some healthcare providers and physicians, breaking bad news to an elderly end-stage client may be taken for granted because the public mindset is wired to assent to end-of-life deaths. While this tendency appears controversial by itself, communicating bad news to younger patients with life-threatening irremediable diseases appears more perplexing, which should be given due attention in practice and special priority in training.

Young patients hope for life rather than death because children conceive of disease as a temporary stage of abnormal functioning of body systems; never do they expect to die if they become ill. The concept gradually transforms; for instance, school-age children may tend to blame themselves by attributing illness to their own actions, but as they grow up, illness becomes increasingly attributed to external causes. Therefore, such conceptualizations should guide healthcare providers' behavior toward their patients (2). Consequently, adopting an oversimplified non-humanistic approach may develop a detrimental trend in communicating bad news to children suffering from incurable diseases. Otherwise, a simple hospitalization or a series of laboratory tests may catastrophically turn into a shocking termination of life, particularly if a young one is hopelessly given an end-stage diagnosis.

Informing the suffering child about the imminent threat of death, therefore, requires special consideration.

Due to critical considerations in breaking bad news, strategies and priorities are found in literature. Most of them stress using structured listening to what the patient knows and wants to know, giving information step by step in understandable segments, reacting to the news, and checking for patients' comprehension. For example, the SPIKES model was first published for delivering bad news to cancer patients; here, S stands for setting, P for perception, I for invitation or information, K for knowledge, E for empathy, and S for summarize or strategize (3). SPIKES has been widely used by clinicians to communicate difficult news to patients in a clear, supportive and compassionate way. Similarly, Rabow and McPhee suggested a model for delivering bad news called ABCDE: A (advance preparation); B (build a therapeutic environment/relationship); C (communicate well); D (deal with patient and family reactions); and E (encourage and validate emotions) (4).

As for life dimensions, primary care providers may consider patients' physical comfort, together with their spiritual and emotional needs. The latter requires special attention when children are the recipient of the difficult news because they express strong forms of emotions and expect due childlike feedback rather than mechanistic reactions grounded in medical logic. Clinicians are further expected to recognize that the kid is dying and needs caring and support rather than medication alone (5). As a complementary route, palliative care providers tend to create peaceful moments in the rest of life and regard dying as a normal process. While this approach neither hastens nor postpones death, it aptly provides relief from pain and other distressing symptoms (6).

This short communication is an attempt to bring the core of these perspectives into the forefront. As briefly noted, the few strategies listed above may have unintentionally prevaricated the emotionally interactive nature of delivering difficult news. This shortcoming finds more prominence when the recipient is a child who expresses their emotions more strongly compared to an adult. While being honest and tactful in explaining the disease to the child and parents in simple terms is essential, more essential steps may include letting the child take turns in communication, speaking up their emotions and fears, asking questions, showing emotions by crying or even yelling at you, and shaping a true conversation rather than a unilateral conveying the message. In fact, the message may efficiently settle if you take time, avoid short and brief statements, break the silence, encourage the flow of emotions, wait for their reactions, use physical cues such as patting on their shoulder or hugging if culturally allowed, and preparing hourly follow-ups in successive turns. Undeniably, parental support should be sought to ease the interaction. This is not a single-step one-way communication because a young child suffering from a difficult disease will reflect an incredible load of

reactions before accepting termination of life upon a clinician's comments. To conclude, the concept of dying for a child may be culturally associated with complex concepts such as heaven, flight, meeting the maker, joining the glory, etc. So, in addition to understanding the nature of breaking bad news to end-stage children, clinicians need special training to develop effective communication skills in this regard (7).

Conclusion

None.

Acknowledgment

None.

Conflict of Interest

There is no conflict of interest.

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How to Cite This Article:

Shomoossi, N., Rad, M. Delivering Bad News to End-Stage Children: Emphasizing the Role of Emotions. *J Obstet Gynecol Cancer Res*. 2023; 8(3):306-7.

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