Indian Journal of Surgery (February 2022) 84(1):3–6
https://doi.org/10.1007/s12262-021-03092-7

EDITORIAL

Breaking Bad News of Surgical Complications in India

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Received: 26 July 2021 / Accepted: 21 August 2021 / Published online: 30 August 2021

Introduction

> "An expert in breaking bad news is not someone who gets it right every time, he or she is merely someone who gets it wrong less often and who is less flustered when things do not go smoothly" …..R. Buckman

Bad news in surgery is a situation where there is either a feeling of no hope, a threat to one's mental or physical well-being, a risk of upsetting an established life style or where the message given conveys fewer choices in his life following or during an operation. Bad news is defined as "any news that drastically and negatively alters the patient's view of her or his future" [1].The art of delivering the bad news about the unexpected surgical complication to the patient and his relative effectively and empathically is something every surgeon should learn and master on his own as there are very few peer reviewed surgical literature on this issue. A concern about breaking surgical complication suddenly is how the news is going to have an immediate reaction from the patient and his relative. All the lacunae which are there in most of the time during the delivery of the bad news after the surgery need to be addressed and sorted out so that a junior or trainee surgeon learn this art effectively without a prolong learning curve.

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Dilemma of the New Surgeon

> "No matter what measures are taken, doctors will sometimes falter, and it isn't reasonable to ask that we achieve perfection. What is reasonable is to ask that we never cease to aim for it" Atul Gawande [2]

Communication failures are the most common cause of errors, adverse events, and malpractice claims for surgical patients. Despite this, communication research to improve evidence and inform quality practice in the operating room has remained limited. Olson et al. concluded in a study that there is a significant difference between the patient and the physician's impression about patient's knowledge and inpatient care received. Seventy-three percent of the patients thought that there was only one main physician and 18% correctly named the physician compared with 67% of physician who thought patient knew their name. Seventy-seven percent of the physicians believed that the patient knew their diagnosis but only 57% of patient was aware of their disease. Ninety-eight percent of the physicians stated that they had at least sometime discussed the patient's fear and anxieties but on the contrary, 54% of patient said physician never did any type of communication with them [3].

Several studies done on breaking bad news to the patient found an increase in cortisol and sympathetic autonomic hyperactivity in the trainee surgeon including tachycardia, systolic hypertension, and stress [4]. In a survey of Paediatricians including resident and trainees in an academic institute, it was seen that 73% of the trainees and 66% of the physician felt inadequate when communicating bad news [5]. The classical traditional surgical training including that of delivery of bad news taught to the trainees—" See one, do one, teach one" is getting ineffective due to time constraints, disinterest of the trainees and personal fear among the teachers regarding honest and truthful confession. So young surgeons are almost never taught to confront an uncomfortable situation during training and have no idea how to tackle the situation when they start practising on their own. Health care workers in the front facing an unexpected surgical mishap

is regarded as a "Second victim" due to fear, panic, guilt, embarrassment, humiliation, anxiety, depression and mental agony. Among the various professions working in the operating room, perceived hierarchies are common (e.g., surgeons *vs*. non-surgeons; physicians *vs.* nurses; staff *vs*. trainees; senior staff *vs*. junior staff), which then lead to barriers to effective communication.

Phases to Discuss Inadvertent Surgical Complication

There are 3 phases to discuss a surgical complication or error with the patient and his relatives –

Phase 1 (During surgery)—whenever an unforeseen event occurs in the intraoperative period, it is important to counsel the patient party that surgery will take a bit longer time and the surgeon is doing his best with some special gadget or equipment, but he is in control and taking good care of the patient.
Phase 2 (Immediately following surgery)—when the patient is in the recovery room, the surgeon takes a deep breath, sits down, explains the problem, tells them the possible options and way out, apologize and reassure the relatives.
Phase 3 (Long term)—it's important to stay in touch with the patient, call and guide them to tackle the complication, e-mail them routinely and navigate them till the problem is solved. Keep your successes close but your failures closer.

The technique of delivery of bad news are of 3 types, can be blunt and abrupt within 30 s, forecasting where there is a pre-emptive warning and step wise approach between 30 to 120 s and finally stalling where bad news is delivered after more than 120 s describing detailed information and steps which lead to the complication. 45% of the physician used the forecasting approach technique, 37% had blunt approach and 18% used the stalling approach to deliver the bad news [6].

There are two well-established protocols for the delivery of bad news to the patient. SPIKES protocol (S—setting up the interview, P—accessing the patient's perception, I—obtaining the patient's Invitation to the type and depth of information they want, K—provide Knowledge and information to the patient, E—addressing the patient's Emotional and Empathic responses, S—strategy and summary of the next steps and treatment plans of the complication) [7].

There is a ABCDE protocol where A is Advance preparation, arrange adequate time and privacy, confirm medical facts, review relevant clinical data, and emotionally prepare for the encounter; B is building a therapeutic relationship; C is communicating well without any medical jargon; D is dealing with patient and family reactions; and E is encouraging emotions and offer realistic hope.

There is no doubt that the SPIKES protocols are the most popular and widely accepted and has contributed hugely towards professional practice, but evidence accumulated over the past 15 years suggests that certain adaptations could potentially better reflect clinical reality, patient preference and professional need. The protocol should focus on professions other than medicine and should also support the health professional in their emotional labour. In ABCDE protocol, specific situations may preclude carrying out many of these suggestions, the recommendations are intended to accommodate as a general guide and should not be viewed as extravagantly prescriptive.

The fact remains that even in the setting of realistic expectations, communicating with distressed patient is difficult. Perhaps, one of the reasons is in the name—it is bad news that the clinician deals with and dealing with human tragedy is never easy, irrespective of however skilled one may be, and may lead to the burnout of the operating surgeon [8].

Effective Communication Skills for Bad News Delivery

Any effective communication has 3 basic components—verbal, nonverbal, and paraverbal. Verbal component deals with the content and selection of the words, non-verbal component deals with the posture, gesture, facial expression, and spatial distance. Paraverbal component include tone, pitch, pacing and volume of the voice. It is seen that the surgeon concentrates only on the verbal component that constitutes only 10% of the communication delivery and misses out the crucial 90% nonverbal and paraverbal component [9]. Dr Gordon Wood from Feinberg School of Medicine quotes, "One mistake students often make is they get so focussed on the medical information that they forget to recognize the emotional impact of the news on the patient." It has been seen that in a high-volume emergency department, it is crucial for doctors and nurses to be endowed with skills of "short bursts of frequent communication" to accomplish an efficient, safe, and patient centred care for all [10].

The Operating Room Black Box® (SST Inc., Toronto, ON, Canada) is an appealing solution to the challenge of comprehensive communication assessment [11].

Preoperative Good Communication Skills

Poor or substandard communication with the patient and his relatives about the risk, prognosis, possible complications and morbidity leads to emotional flareup incidences in most

of the cases. Therefore, good pre-operative counselling, taking informed consents explaining all the eventualities, video counselling in some difficult cases, goes a long way in preparing the patient's mind and increasing the chances of the party accepting bad news in a calm, rational manner. Surgeon should discuss the operative risk and complications not only with the patient, but with other members of the team like anaesthesiologist, scrub nurse and the operation assistant. Every surgical complication should be documented in the operative record and regular morbidity and mortality meetings should be held to discuss the complication with senior members and junior trainee surgeons.

Bad news should be delivered in a quiet, comfortable, and private location with no interruption, at the convenience of the patient. The surgeon should find out what the patient already knows, convey reassurance, allow for emotional expression and communication, should avoid any medical jargon, deliver with empathy avoiding playing down the problem or change the topic of discussion. Any untimely jokes should be avoided, and a direct eye contact should be maintained with the patient [11]. Since most of the patient family members will "Google" all about the complication, the surgeon should prepare to answer all these questions coolly and with full confidence.

When the bad news delivered impacts survival or a pain-free life of a patient, he may even try to commit suicide and he should be reassured and not allowed to drive back home all alone. Every effort should be made to satisfy the "4 Cs " in the patient: caring, curious, concerned, and confused.

Teaching Communication Skills to Medical Students

In a study on the medical students of Botswana to demonstrate effectiveness of an educational training workshop using role-playing to deliver the bad news, it was seen that the competency for delivering bad news increased from a mean score of 14/25 (56%, $SD = 3.3$) at baseline to 18/25 (72%, $SD = 3.6$) after the workshop ($p = 0.0002$) [12]. The development and use of empathy could be promoted in the medical students by increasing hands-on-experiences, possibilities to experience the patient's point of view and offering patient contact early in the curriculum. Mentoring-relationships, with older students or postgraduate students, could support students by counteracting the negative effects and stress of delivering the bad news.

Breaking Bad News of Iatrogenic Intraoperative Death

Except in malignancy and in emergency conditions, any intraoperative mortality due to either surgical complication or anaesthetic mishap may lead to sudden emotional outburst and communication of such news to the patient's family is extremely challenging as they may not reconcile to the fact that an elective surgery has resulted in a sudden death. For the surgeon, it causes profound grief, loss of self-esteem, lack of self-confidence, sudden loss of reputation and image in the society and medicolegal harassment. A team approach comprising of one or two members of the anaesthesia and surgical department, a senior matron or head nurse, chaplain or social worker is recommended in such a time.

Dan Taylor et al. have recommended a two-phase approach to communicate with a family member of intra-operative death. Before death—proactive phase " CARE" (C—Create Credibility and establish fiduciary responsibility, A—articulate the purpose of the operation, R—relate to the whole person in body, mind, and spirit, E—empathize). After death—a reactive phase "SHARE" (S—scrutinize the case provided perioperatively, H—honesty and humbly acknowledging errors, A—Articulate the circumstances of the death, R—reassure, E—ensure self-care) [13].

Problem in India with the Iatrogenic Surgical Bad News

In a country where 82.7% doctors feel stressed out in the profession, 46.3% fear violence is the main cause of stress, 24.2% doctors fear being sued and 56% of doctors don't get a comfortable 7-h sleep most days of the week, it becomes a real threat to the surgeon to openly talk to the highly emotional family members of the aggrieved family, as the incidence of workplace violence and manhandling of the medical staff are very high on such occasions (https://www.hindustantimes.com/health/majority-of-indian-doctors-fear-violence-are-stressed-says-indian-medical-association/story-sN9rHa6rziLCjd15DJUoxJ.html). In government hospitals, errors occur which cannot be rectified because of inadequate infra-structure that the patient party does not want to condone. In private hospitals, since the maximum number of patients do not have insurance, and pay for the surgery out of their savings, they do not want to even think of a post-operative complication, let alone death.

There is always a need for a preoperative audio-visual recorded informed consent with preoperative, intraoperative, and postoperative documentation of everything happening inside the operation theatre during the complication. Seeking a second opinion from another senior surgeon or anaesthesiologist is encouraged. Since there will be invariably involvement of local politicians, print and social media immediately in such an event, the surgical team should have the courage and the resilience to withstand all without getting irritated or provoked. The surgeon and the hospital should have a sound Consumer court insurance. Code purple may need to be flagged in such a time.

In China, mobs called "Yinao" regularly protest at hospitals or harass the hospital administrator whenever there is some iatrogenic error, for money [14].

Conclusion

In the ideal of circumstances, when a surgeon does his job, there might be complications or death of the patient as there are so many variables like the patient factors, the surgeon factors and the sudden changes in the conditions during the surgery. Every trainee surgeon should be taught not only the surgical expertise to handle the complications, but to deal with the situation and break the bad news to the patient and the relatives, deal with personal guilt and shame too, and do it in such a way that will not smear his reputation and cause him personal harm. Patient communication is an essential art, taking responsibility for your actions, showing empathy and care, making the patient party understand that all possible effort was done to prevent the complication and salvage it, will go a long way in keeping the health and sanity of the surgeon intact. And it is time that this art is given the importance it deserves in surgical training.

> "The life of a sick person can be shortened not only by the acts, but also by the words or the manner of a physician. It is, therefore, a sacred duty to guard himself carefully in this respect, and to avoid all things which have a tendency to discourage the patient and to depress his spirits." American Medical Association's first code of medical ethics (1847).

Declarations

Conflict of Interest The authors declare no competing interests.

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