The Oncologist®

Commentary

Breaking Bad News via Telemedicine: A New Challenge at Times of an Epidemic

Ido Wolf,[a,b] Barliz Waissengrin,[a] Sharon Pelles[a,b]

[a]Division of Oncology, Tel Aviv Medical Center, Tel Aviv, Israel; [b]Sackler School of Medicine, Tel Aviv University, Tel Aviv, Israel

Disclosures of potential conflicts of interest may be found at the end of this article.

I (B.W.) met H.K., a 56-year-old woman, 2 years ago when she was diagnosed with metastatic gastric cancer. Together we passed through times of joy, when treatment worked and she felt well enough to meet her new granddaughter, as well as more challenging times when disease progressed. On February 2020 after exhausting three lines of treatment, she started to suffer from back pain and abdominal distension; the computed tomography scan revealed new progression of her disease. I prepared myself for the most significant meeting, the one in which we would discuss moving from active treatment to best supportive care. Then came the COVID-19 epidemic. H.K. could not come to the hospital, and we conducted the conversation via telemedicine. After two sentences in which I described the situation, she started crying. I couldn't look in her eyes or touch her hand to calm her. We both were helpless.

The skills and art of breaking bad news are an essential part of the oncology profession and are extensively taught throughout training. Breaking bad news, defined as "any information which adversely and seriously affects an individual's view of his or her future" [1], includes not just the initial diagnosis but also relapse, palliative care transition, and end-of-life transition [2]. Thus, patient visits involving at least some components of breaking bad news are relatively common in any active oncology clinic. Various models for breaking bad news have been developed and implemented, with the six-step SPIKES protocol being one of the most extensively used [3]. The steps include (a) *setting up* the interview, (b) assessing the patient's *perception*, (c) obtaining the patient's *invitation*, (d) giving *knowledge* and information to the patient, (e) addressing the patient's *emotions* with empathic responses, and (f) *strategy and summary.*

The outbreak of the COVID-19 epidemic is rapidly transforming the most basic component of interaction and communication between patients and physicians: the face-to-face meeting. The worldwide instructions for social isolation were accompanied by guidelines from major oncology associations to conduct appointments via telemedicine (e.g., the COVID-19 Provider & Practice Guidelines by the American Society of Clinical Oncology [4]). Although conducting telemedicine for routine and often administrative purposes does not seem to pose unique challenges and even has some benefits, breaking bad news via telemedicine is a whole new story, to which the currently available models simply do not apply.

At our center, telemedicine was already fully implemented in early March 2020, and visits were limited only to new patients and for active treatment (radiation, IV medications). It took only few days of telemedicine until we had to deliver all types of bad news to our patients. These visits could not be done in person, not just because of rules and regulations, but mostly because of these high-risk patients' fear of leaving home. An example of the obstacles facing the oncologists is the first and maybe most critical step of the SPIKES model: setting up the interview. Any difficulties here may hamper the next steps. Implementing measures usually taken under these steps using telemedicine seems almost impossible:

a. Arrange for privacy, sit down: this step is now in the hands of the patients. Some patients, mostly elderly patients, need assistance with the telemedicine application. Moreover, some patients answer telemedicine at unexpected locations (driving, shopping for essentials) or together with very young children.
b. Involve significant others: when many patients are under social isolation, the patient is often alone when interacting. Thus, in this crucial time when support is needed for absorption of the news, the patient is by him- or herself.
c. Make connection with the patient: the most basic form of connection between human beings involves physical interaction (a handshake, a hug) and body language (eye contact, a smile). These are obviously absent. Their comforting, holding role is missing. Furthermore, different accessories in the physician's room, such as family pictures, which help build a connection are missing, thus increasing the risk of psychological distance [5, 6].
d. Manage time constraints and interruptions: telemedicine interactions are prone to communications interferences, lapses, delays, and cuts. When these appear in the most meaningful sentence, the effect is daunting.

Correspondence: Barliz Waissengrin, M.D., Division of Oncology, Tel Aviv Medical Center, 6 Weizman Street, Tel Aviv, Israel. Telephone: 972-3-6973815; e-mail: barliz28@gmail.com Received April 8, 2020; accepted for publication April 8, 2020; published Online First on April 28, 2020.

When silence occurs, both sides are unable to learn if this is an emotional cue that more silence or a comforting sentence is needed or if it rather is the interference of bad connection.

Similar problems are being encountered throughout the six-step system. We can imagine the end of such a visit in the clinic, with adequate closure and physical interaction, looking in the eyes, holding hands, a hug, or even just empathically escorting the patient and the family on their way out of the clinic and maybe answering some of the most difficult questions on the way. This cannot be done through telemedicine.

A year before the COVID-19 pandemic, an article published in many popular media venues reported on a story titled "Doctor delivers end-of-life news via 'robot,' leaving family frustrated" [7]. The story raised a lot of criticism of the use of technology in breaking bad news. However, attitudes seem to be changing rapidly at times of crisis. The COVID-19 pandemic is expected to stay with us for at least a few more months, and many of the practices used at this time are likely to remain even when it is gone. To our knowledge, the issue of breaking bad news using telemedicine has not been studied yet. It is therefore essential to build and implement tools for the new era of breaking bad news using digital media. A first step should be rapid research among patients and physicians, looking at the technical challenges as well as values, beliefs, and suggestions for action. The next step should be the design and implementation of education programs and measures to physicians and patients alike, aimed at the delivery of bad news to patients in the most compassionate and effective way.

Disclosures

The authors indicated no financial relationships.

References

1. Buckman R. Bad News: A Guide for Health Care Professionals. Baltimore, MD: Johns Hopkins University Press, 1992.

2. Bousquet G, Orri M, Winterman S et al. Breaking bad news in oncology: A metasynthesis. J Clin Oncol 2015;33:2437–2443.

3. Revah-Levy A, Baile WF, Buckman R et al. SPIKES - A six-step protocol for delivering bad news: Application to the patient with cancer. ***The Oncologist*** 2000;5:302–311.

4. COVID-19 Provider & Practice Information. American Society of Clinical Oncology Web site. Available at https://www.asco.org/asco-coronavirus-information/provider-practice-preparedness-covid-19.

5. Stoeckle JD. The good relation. In: Stoeckle JD, ed. Encounters Between Patients and Doctors: An Anthology. Cambridge, MA: MIT Press, 1987.

6. Miller EA. The technical and interpersonal aspects of telemedicine: Effects on doctor–patient communication. J Telemed Telecare 2003;9:1–7.

7. Shannon J. Doctor delivers end-of-life news via 'robot,' leaving family frustrated. USA Today, March 9, 2019. Available at https://www.usatoday.com/story/news/nation/2019/03/09/california-hospital-robot-delivers-end-life-news-family-outraged/3113760002/.