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Communicating difficult news: a medical perspective in the context of neurology

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Abstract

This study investigated the challenges faced by neurologists in communicating difficult news in an oncology hospital. A descriptive, quantitative-qualitative methodology was adopted, and the study was conducted from August to October 2024, after approval by two Research Ethics Committees. In total, 12 physicians participated, including neurologists, neurosurgeons, and resident doctors from the Ophir Loyola Hospital in Belém, who responded to a questionnaire on the communication of difficult news. The results revealed differences in how specialist doctors and residents engaged with the topic, especially during their academic training. Although participants positively assessed their preparedness to handle difficult communications, challenges persist, particularly a lack of communication skills, inadequate environments, and insufficient team support. The study highlighted that communication protocols and clinical experience are important allies in promoting humanized care.

Keywords: Health communication. Truth disclosure. Neurologists. Cancer care facilities.

Resumo

Comunicação de notícias difíceis: perspectiva médica no contexto da neurologia

Este estudo investigou os desafios enfrentados na comunicação de notícias difíceis por neurologistas em um hospital oncológico no Pará. Adotou-se uma metodologia com abordagem descritiva e quanti-qualitativa, com realização nos meses de agosto a outubro de 2024, após aprovação por dois comitês de ética em pesquisa. Participaram doze médicos, incluindo neurologistas, neurocirurgiões e médicos residentes do Hospital Ophir Loyola, em Belém, os quais responderam a um questionário sobre comunicação de notícias difíceis. Os resultados demonstraram diferenças em como médicos especialistas e residentes tiveram contato com o tema, especialmente durante a formação acadêmica. Embora os participantes tenham avaliado de forma positiva seu preparo para manejar comunicações difíceis, existem desafios a serem enfrentados, com destaque para a falta de habilidades comunicacionais, ambiência inadequada e ausência de suporte à equipe. O estudo destacou que os protocolos de comunicação e experiência clínica são importantes aliados no cuidado humanizado.

Palavras-chave: Comunicação em saúde. Revelação da verdade. Neurologistas. Institutos de câncer.

Resumen

Comunicación de noticias difíciles: perspectiva médica en el contexto de la neurología

Este estudio evaluó los desafíos que enfrentan los neurólogos en la comunicación de noticias difíciles en un hospital de oncología de Pará (Brasil). Se utilizó una metodología de enfoque descriptivo y cuanti-cualitativo, realizada de agosto a octubre de 2024 después de la aprobación de dos Comités de Ética en Investigación. Participaron 12 médicos, entre neurólogos, neurocirujanos y médicos residentes del Hospital Ophir Loyola, en la ciudad de Belém, quienes respondieron un cuestionario sobre cómo comunicar noticias difíciles. Los resultados revelaron diferencias en la forma en que médicos especialistas y residentes tuvieron contacto con el tema, especialmente durante su formación académica. Aunque los participantes evaluaron positivamente su preparación para manejar comunicaciones difíciles, hay desafíos que enfrentar, en particular la falta de habilidades de comunicación, un entorno inadecuado y la falta de apoyo del equipo. Se destaca que los protocolos de comunicación y la experiencia clínica son aliados importantes.

Palabras clave: Comunicación en salud. Revelación de la verdad. Neurólogos. Instituciones oncológicas.

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Update

The topic of communicating difficult news has gained increasing visibility in medical training and practice, and is considered an indispensable skill today, especially given the ethical and humanistic aspects that underpin the practice of the profession [1]. In the field of clinical health, its importance stems from the fact that some news can be difficult to manage due to its emotional impact on patients, families, and the medical team [2].

While the disclosure of difficult information is part of daily medical practice, some of it can negatively impact expectations for the future and, therefore, trigger various emotional reactions [3]. Thus, the physician must be able to offer support and comfort to patients and families, which requires a set of interpersonal skills in the communication approach [4].

In this scenario, ethical issues also need to be considered, as they will affect the content and how the news is communicated. In the context of serious or terminal illnesses, such as cancer, clear and empathetic communication is even more crucial, since patients and their families need to cope with unwelcome and often unexpected news. Thus, the medical team also needs to be prepared to manage information, including disclosures of difficult truths that disrupt expectations and treatment plans [5].

In neurology, these challenges take on specific contours, given the complexity of some neurological diseases and their impacts on the quality of life and mental health of patients, which makes the topic relevant in this scenario [6]. However, despite the communication of difficult news being a central and challenging component of neurological clinical practice, there remains a scarcity of studies addressing the topic [7].

Considering the relevance of such discussions in the field of neurology, this study sought to investigate the challenges faced by clinical neurologists, neurosurgeons, and neurosurgery and neurology residents in communicating difficult news, using a reference hospital for clinical neurology and oncology treatment located in the state of Pará as a research setting [1].

Method

The study was conducted through field research, with a descriptive, exploratory, and quantitative-qualitative approach, carried out between August and October 2024. The research began after approval by two Ethics Committees, with Certificate of Presentation for Ethical Consideration.

Participants in the study were neurologists, neurosurgeons, and residents at Ophir Loyola Hospital (HOL), an institution located in the municipality of Belém, state of Pará, that offers care in various medical specialties, including neurology. Data collection took place in person, following prior contact with participants, with participation conditioned on signing the informed consent form.

The study protocol included a questionnaire designed by the authors to meet the research goals. The instrument had open- and closed-ended questions across four sections: knowledge and perception of "communicating difficult news," prior exposure to the topic in medical training, self-assessment of communication skills regarding difficult news, and knowledge of strategies, guidelines, and protocols for this communication. In open-ended questions, participants identified challenges in communicating difficult news, considering HOL's work context.

In the quantitative analysis, descriptive statistics were used, resulting in a set of numerical measures and graphs to present the findings. In the qualitative analysis, the content analysis method was used [8], through a systematic process of understanding the meaning and significance of the responses, consisting of three phases: pre-analysis, exploration of the material, and treatment and interpretation of the results. The choice of a quantitative-qualitative approach was motivated by the aim of incorporating elements of participants' speech, thereby making their personal experiences visible.

Results

Twelve professionals participated in the study, six (50%) specialists and six (50%)

residents. Among the specialists, four (66%) were neurologists and two (33%) neurosurgeons. Among the residents, three (50%) were from the neurology area and three (50%) from neurosurgery. Of this total, ten (83.3%) were men and two (16.6%) were women. In the group of neurologists/neurosurgeons, ages ranged from 36 to 59 years, with a 44.6 years mean. Regarding the residents, ages ranged from 28 to 35 years, with a 31.1 years mean. Among neurologists/neurosurgeons, the average time since graduation was 21.1 years; among residents, 5 years. Regarding the length of service at the hospital, the mean length of service was 11.1 years for physicians and 1 year and 7 months for residents, with 3 being R1, 2 R2, and 1 R4.

Initially, participants were asked if they were familiar with the expression "communicating difficult news," and 11 (91.6%) responded affirmatively. Of this total, five (45.4%) were specialist physicians and six (54.5%) were residents. Only one (8.3%) specialist physician responded negatively.

When asked to express their perception of the subject, responses converged on a core meaning that pointed to a relationship with the diagnosis of a serious illness, without the possibility of curative treatment and/or representing a threat to the continuity of life, with no differences between specialist physicians and residents. In addition, two participants mentioned the word "protocol," and another the word "art," both referring to the process that characterizes the communication of difficult news. Below are some expressions used by participants in response to open-ended questions:

"Heavy words in listening, understanding, and communicating clearly and empathetically" (P2).

"Protocol that aims to systematically inform about reasons regarding the patient's health, considered unpleasant" (P3).

"The art of communicating news with unfavorable outcomes or poor prognoses regarding the patient's health condition to patients and families" (P6).

"Communicating bad news in a gentler way" (P10).

Analyzing the justifications, the expression is noted to describe a set of information with a negative or unfavorable treatment prospect.

"Communicating permanent deficits, death, impossibility of treatment/surgical approach" (P8).

Regarding academic background, participants were also asked how often the subject had been addressed. Of the total, no participant said "always." Among specialist physicians, one (16%) said "sometimes"; two (33%), "rarely"; and three (50%), "never." Among residents, four (66%) answered "sometimes"; one (16%), "rarely"; and one (16%), "never."

In the context of clinical practice in neurology and neurosurgery, participants were also asked to rate their skill to communicate difficult news to patients and family members/caregivers. Proportionally, it was observed that among the participants, 66% rated their skill to communicate difficult news to patients as "good," with 41% being specialist physicians and 25% resident physicians. Furthermore, 16% rated it as "excellent," all of them residents. One specialist physician (8%) and one resident (8%) rated it as "fair."

Regarding the skill of communicating bad news to family members/caregivers, 58% rated it "good," with 33% being specialist physicians and 25% residents. Of the remainder, 25% rated it as "excellent," with 8% being specialist physicians and 16% residents. A further 16.6% rated it as "fair," with half being specialists and the other half residents.

When asked whether participants agreed that physicians have a duty to inform patients of their diagnosis and prognosis, responses showed a predominance of both criteria for "always" communicating with the patient: 100% for the diagnosis and 91.6% for the prognosis.

Considering a set of response options presented, participants were asked to indicate the factors that most influenced the decision to communicate difficult news, with the item with the highest frequency of responses highlighting the patient's right to have access to information (n=12),

followed by the understanding that it is a professional duty (n=10), the patient's emotional state to receive the information (n=8), the family's concerns and/or requests regarding the information (n=4), and the patient's active role in the physician-patient relationship (n=3). The least frequent item highlighted was the pressure of feeling judged and/or accused of withholding information (n=1).

When asked whether they adopted any strategy, guideline, or protocol for communicating difficult news, 10 responded affirmatively and 2 negatively; the latter 2 were specialist physicians. Among those who answered "yes," eight (80%) mentioned the SPIKES Protocol. However, 2 (20%) participants emphasized that they use strategies in their communication approach, without directly mentioning a specific protocol for this purpose. The following excerpts exemplify this statement:

"I try to find out about the patient: life, family, work, religion, others. Then I let the patient ask questions. I make myself available so that together we can find the best path, with a reassessment of the processes" (P1).

"I always try to be as honest as possible, because it's important for patients to know what they have. However, I respect their wishes or their fragile situation. I believe we should be honest and truthful without being harsh" (P6).

Regarding challenges in hospital clinical practice, participants were asked whether they had ever refrained from communicating difficult news due to fear or concern about the patient's possible emotional reaction. Of the total, five (41%) answered "yes," of which 80% were specialist physicians. Furthermore, seven (58%) answered "no," with 71% of these responses coming from residents. Regarding patients' family members, two (16%) said "yes," and ten (83%) said "no."

Participants were asked whether they had ever refrained from communicating difficult news to avoid disrupting the patient's sense of hope and/or optimism. Two (16%) stated that "sometimes," both of whom were specialist physicians. Furthermore, five (41%), all residents, had never refrained from communicating difficult news in such a context.

In hospital settings, participants were asked to choose the option they considered most difficult to communicate. The most frequent response was worsening and/or irreversibility of the clinical condition (n=8), followed by an unfavorable patient prognosis (n=5). Referral to the intensive care unit (ICU) and death were not chosen as response options. Table 1 presents the results.

In the open-ended responses, participants could justify their choices in a discursive manner. As can be seen in Chart 1, three categories of responses emerged that were prominent in the justifications provided by the participants.

Table 1. Situations most difficult to communicate, according to the participants' opinion

Considering your role at HOL, what situation do you find most difficult to communicate?	Specialist physicians (n)	Specialist physicians (%)	Resident physicians (n)	Resident physicians (%)	Total participants (%)
Worsening and/or irreversible clinical condition	3	25.0%	5	41.67%	66.67%
Unfavorable prognosis	2	16.67%	3	25.0%	41.67%
Brain death	2	16.67%	1	8.33%	25.0%
Referral to palliative care	1	8.33%	2	16.67%	25.0%
Death	0	0.0%	1	8.33%	8.33%
Diagnosis	0	0.0%	0	0.0%	0.0%
Referral to ICU	0	0.0%	0	0.0%	0.0%
Other	0	0.0%	0	0.0%	0.0%

HOL: Hospital Ophir Loyola; ICU: intensive care unit.

Chart 1. Responses and discourses of the participants

Response category	Discursive content
Seriousness and irreversibility of the disease	P1: "Life is a fundamental gift. Talking about death and the irreversibility of a condition requires an appropriate moment, and it is not easy to face this moment." P5: "Outcomes where there is nothing more I can do to help the patient still sadden me greatly."
Broken expectations and/or hope	P2: "Because there is a loss of hope at that moment." P3: "The impossibility of returning to their familiarity or the absence of treatment, the shock more than the diagnosis itself." P8: "Family members and the patient themselves tend to believe that the surgical approach will always be the cure for the disease." P9: "Unsatisfactory outcome and expectations." P10: "The difficulty of delivering the news of a poor prognosis and the termination of palliative care is the delicate part, because that is when the patient loses hope most of the time."
Poor understanding and acceptance of the clinical condition	P4: "Little understanding that patients have about some diagnoses; acceptance by patients/family members about irreversible/progressive pathologies." P6: "I realize that families here in the North have difficulty accepting/understanding scientific death, sometimes due to educational issues, other times religious ones."

Finally, participants were asked to describe the challenges they faced in communicating difficult news at the hospital, as this information was important for identifying possible particularities of this institutional setting. Furthermore, since some participants also worked in private practice, investigating variables inherent to medical interventions was required, given that this is a leading oncology hospital that receives patients from different municipalities and states, with diverse diagnoses and prognoses. In the open-ended questions, five categories of responses emerged with significant impact (Chart 2).

Chart 2. Response categories

Response category	Discursive content
Lack of preparedness to communicate difficult news	P1: "I believe that interference from inappropriate speech or from a healthcare professional and/or the presence of a close family member who does not help in the process." P3: "Lack of structure for communicating bad news, absence of a team that effectively applies the protocol." P4: "Little/absence of training for new healthcare professionals at the hospital regarding the communication of bad news." P6: "A team is needed, neurosurgeons (physician), psychologist, social worker to first identify the patients/family members regarding the profile of the person we are talking to for better diagnosing how to approach them and treat them with the correct words that we can reach them."
Difficulties in understanding the information	P2: "Patient's level of education and lack of support available at the outpatient level." P8: "Understanding, as patients and family members generally have a low level of education and erroneous expectations." P9: "The biggest challenge is the level of education of the target population, which makes understanding difficult." P10: "Lack of understanding and low level of education, and lack of an appropriate channel for discussing the scope of the news of a difficult outcome."

continues...

Chart 2. Continuation

Response category	Discursive content
Inadequate environment	P4: "Absence of an appropriate space to communicate bad news; little/absence of training for new hospital healthcare professionals regarding the communication of bad news."
Lack of emotional support for the medical team	P5: "Lack of care, from a psychological point of view, for the professional who delivers bad news. We have to deal alone with the feeling of helplessness, sadness, anger and other feelings, which are natural to have when building a good physician-patient relationship."
Seriousness of the clinical condition	P7: "Patient with a very reserved prognosis."

Some relevant findings warrant discussion, as communicating difficult news is an essential skill for physicians, especially those in neurology, an area where they frequently encounter serious, incurable, and potentially life-threatening conditions. Furthermore, in the context of an oncology hospital, this communication becomes even more critical due to several particularities of the neurology setting, including the complexity of treatment and the risks inherent in surgical procedures [9].

It is worth noting that teaching about communicating difficult news during medical students' academic training is crucial to preparing future physicians for the emotional and ethical challenges of clinical practice. The inclusion of training in communicating bad news in medical education allows students to develop essential skills for effective clinical interactions, promoting greater confidence and competence in delivering difficult news and helping reduce anxiety and stress for both physicians and patients [10].

Due to the small number of participants in the study, it was not possible to determine whether the differences between specialist physicians' and residents' responses were significant, but it is expected that topics of this nature have gained greater visibility in medical education compared with past decades. In fact, the results suggest that resident physicians with more recent academic training have accessed content of this nature more frequently, given that, among those who stated that the topic was "never" addressed, the minority were residents. This finding suggests an advance in the approach to the topic, although it is not widely discussed in the context of neurology [11].

The findings are consistent with the literature, as they reinforce the need to intensify physicians' preparation to manage critical conversations [12]. Furthermore, greater residents' contact with the topic may reflect important changes incorporated into medical curricula. Conversely, for neurologists who graduated longer ago, there may have been fewer opportunities to develop communication skills and competencies.

While most participants reported occasional contact with the topic during their undergraduate studies, the majority rated their skill to communicate with patients as "good," with a higher proportion of hospital physicians than residents rating their skills as "excellent." The data analysis suggests a correlation between recent academic training and self-assessment of communication skills.

Another point to be discussed is reflecting on models of the physician-patient relationship, as Medicine is also going through a period of change marked by a progressive appreciation of autonomy and shared decision-making. These themes have gained greater emphasis, in contrast to a paternalistic relationship model that for a long time predominated in clinical practice [13].

Currently, the physician's duty to inform the patient of their diagnosis and prognosis is increasingly emphasized, with this stance

considered a fundamental responsibility that involves ethical and legal aspects [14]. his attitude is particularly important in the neurosurgery setting, given the complexity of procedures and the risks involved. Clear and effective communication between the medical team and the patient is essential to ensure the safety and success of neurosurgical interventions [15]. In addition, adequate patient preparation, including understanding the risks and benefits of surgery, contributes significantly to reducing complications and achieving a more successful recovery [16].

All participants identified the patient's right to access information as the most influential factor in communicating difficult news, indicating recognition of patient autonomy as a fundamental principle [17]. However, autonomy can only be exercised if patients have been informed about their condition and actively participate in the decision-making process regarding their treatment. Furthermore, a lack of adequate communication compromises the exercise of autonomy and can generate feelings of insecurity, frustration, and distrust in the healthcare system [18].

Respect for autonomy requires neurologists and neurosurgeons to value dialogue and the relationship with their patients, since neurological diseases can also impact the ability to understand information. This practice strengthens mutual trust and promotes more humanized care, and the integration of communication skills into medical training is essential to ensure its widespread adoption [19].

Considering the patient's emotional state when receiving information reveals that medical communication cannot occur in a mechanized way, without a humanistic and empathetic approach, suggesting that participants are aware that the manner and timing of communicating information can significantly impact how the patient copes with the news [20]. Finally, the pressure of feeling judged and/or accused of withholding information was the least cited factor, indicating that most physicians do not perceive the communication of bad news as an obligation imposed by external pressures, but rather as a professional duty.

The adoption of structured strategies and protocols is important for communicating difficult news, but, as some participants reported, physicians end up incorporating strategies into their daily practice that come from experience and their understanding of the subject. Of the total number of participants, the majority stated that they adopt some type of strategy or protocol for communicating bad news; Of these, 80% specifically mentioned the use of the SPIKES Protocol, one of the most widely recognized and used guidelines in Oncology [21].

Adherence to the SPIKES protocol suggests that physicians are attempting to follow a structured approach to minimize the negative emotional impact of difficult news. However, it is crucial to discuss the limitations and challenges associated with protocols such as SPIKES, because although they offer a valuable path, there is a risk that communication will become mechanical or depersonalized if the protocol is followed rigidly [22]. Therefore, it is important that physicians maintain flexibility and individual sensitivity when applying any protocol, adapting it to the specific needs of each patient and situation.

As noted earlier, two participants use their own communication strategies without explicitly mentioning a specific protocol, highlighting a more personalized, perhaps intuitive approach to communicating difficult news. These strategies may include building a trusting relationship with the patient, developing a deep understanding of their emotional needs, and adapting communication to the individual context. However, relying exclusively on intuitive approaches can lead to inconsistent results and increase the risk of improvisation or the trivialization of the communication process.

Similarly, when faced with the need to follow a structured protocol, physicians may struggle to integrate these guidelines into their communication style, leading to rigid, disconnected interactions [23]. Instead of enriching practice, unfamiliarity with protocols can reinforce a mechanical, dehumanized execution, contradicting the central objective of offering empathetic, individualized support.

Thus, the balance between intuition and already known strategies is crucial to prevent communication from becoming purely technical or excessively improvised.

The lack of a formal protocol does not imply the absence of a careful approach; On the contrary, it may reflect physicians' advanced level of experience and interpersonal skills, allowing for more fluid and humanized communication [4]. However, it is necessary to assess whether the non-use of any protocol is due to a lack of preparation and, consequently, to an inadequate approach to conveying difficult news, which can have repercussions for patients, their families, and healthcare professionals.

The challenges neurologists and neurosurgeons face when communicating difficult news are multifaceted, involving both technical and emotional and ethical aspects. The need to balance honesty with sensitivity and empathy is a constant in this process, especially in neuro-oncology, an area in which prognoses are often serious [9]. In this sense, 41.6% of participants, of whom 80% were specialist physicians, reported refraining from communicating difficult news due to fear or caution about the patient's possible emotional reaction. This finding suggests that more experienced physicians may be more cautious or feel a greater emotional burden when predicting patient reactions, possibly because prior experiences shape their approach.

Regarding communication with family members, the findings revealed that a small percentage of participants had avoided communicating bad news to their family, while the majority responded negatively. These results suggest that neurologists and neurosurgeons recognize the importance of keeping family members well-informed and acknowledge their crucial role in supporting the patient. This is very important in neurology and neurosurgery, as many patients experience decreased autonomy and functionality, resulting in greater dependence on family members and caregivers [7].

Preserving patients' sense of hope and/or optimism is often a concern for the medical team, and all specialist physicians stated that they sometimes avoid communicating bad news for this reason. In contrast, all residents never failed to communicate bad news in this context. This difference may reflect a more pragmatic approach on their part, given their more recent, problematizing academic background regarding the right to access information. However, specialist physicians, due to their limited exposure to protocols for communicating bad news during their academic life, may be more aware of the psychological impact of the news and, therefore, more inclined to modulate the information to preserve the patient's emotional well-being, as they have more years of practice [24].

The shattering of expectations and/or hope is closely related to the limitations of treatment options, news that can be devastating for patients and their families [25]. The seriousness, worsening, and irreversibility of the disease are delicate issues to be addressed by neurologists and neurosurgeons. Perhaps that is why referral to palliative care has been highlighted as a delicate moment in dealing with difficult news.

In fact, conveying the worsening and/or irreversibility of the clinical condition was the item with the highest frequency of responses, indicating that revealing the truth to the patient is a complex process, including emotional [26]. As evidenced by the discursive justifications, physicians face considerable emotional pressure when informing patients of a worsening clinical condition.

These aspects underscore the importance of communication skills and the professional's sensitivity in choosing the appropriate time for such discussions. Despite this, participants also highlighted that understanding and accepting the clinical condition can support communication difficulties due to a lack of understanding of the severity of some neurological diseases [17].

These narratives highlight the influence of sociocultural factors on the acceptance and understanding of difficult news, indicating the need for communication approaches that take these variables into account [27], since the challenges in communicating difficult news may also be related to the profile of patients treated in the oncology hospital, especially in neurology. The hospital in question treats patients with serious and often irreversible illnesses, some of whom are

referred to palliative care, which can increase the frequency of situations where difficult news needs to be communicated.

The responses indicated that educational background can hinder effective communication, as the educational levels of patients and their families play a fundamental role in how they interpret and respond to medical information. Thus, patients with low levels of education may have difficulty understanding complex medical terminology and concepts related to diagnosis, treatment, and prognosis [18], especially in neurological diseases.

Communication problems can also lead to misunderstandings, as patients may expect more favorable outcomes than are possible [28]. For example, the belief that an intervention can cure an advanced condition can result in profound frustration when the realities of treatment prove less promising. Furthermore, this situation can negatively impact adherence to treatment and trust in medical recommendations, hindering collaboration between the patient, family members, and the healthcare team [29].

The lack of skill to communicate the news is noted to constitute a significant barrier, since when professionals are unable to discuss the seriousness of the situation in a comprehensible and empathetic manner, they can generate unrealistic expectations and increase the distress of patients and their families [30]. The way the message is delivered can therefore profoundly impact the emotional and psychological state of those involved, as noted in the participants' statements.

It is noteworthy that the presence of a family member can be a fundamental source of emotional support for the neurological patient, helping to mediate the understanding of the information received. However, it can also be detrimental if the family member does not understand or know how to respond appropriately to the situation, as this can create a hostile and confusing environment. In the field of neurology, the absence of this support can leave patients and their families isolated, without the necessary resources to deal with complex information about the disease and treatment, potentially resulting in a vicious cycle of misinformation in which a lack of clarity leads to uncertainty, anxiety, and often, resistance to treatment [26].

"Hospital culture" can also perpetuate inappropriate behaviors when it fails to provide professionals with adequate physical space to deliver difficult news, leaving them uncomfortable in certain situations. The results indicated that the lack of an appropriate environment for communicating difficult news is a concern, as a welcoming and respectful space is essential for effective communication. However, inadequate environments, often found in wards, compromise the privacy and confidentiality necessary for these interactions.

It is worth noting that the emotional pressure of having to manage difficult news without adequate psychological support is a stressful factor for physicians, especially those working in oncology settings. In their hospital routine, these professionals frequently deal with life-or-death situations, which can generate intense emotional pressure. Thus, feelings of helplessness, sadness, and anger are common, especially when physicians are confronted with the suffering of their patients and the inevitability of death [31].

The need to convey these painful realities is therefore a source of great emotional stress, and the lack of a safe space to express and process these feelings can lead to significant emotional burnout, or even to coldness and insensitivity in attitudes [32]. Thus, the absence of emotional support for professionals not only affects physicians but can also affect the quality of the physician-patient relationship.

When physicians deal with their own emotions without support, this can interfere with the bond they form with patients and with how they communicate with them. As a result, the unprocessed emotional burden can cause physicians to avoid open discussions about the patient's condition, leading to evasive or superficial communication and often to the withholding of information [33].

The inherent nuances of delivering difficult news highlight the need for ongoing training that not only teaches communication protocols but also develops the empathy and emotional management skills of neurologists, neurosurgeons, and residents. Mentoring programs that allow residents to interact with more experienced physicians can also be beneficial, as the exchange of knowledge and transgenerational experiences benefits both.

Furthermore, creating safe spaces for discussion and reflection on difficult experiences can help address the emotional and ethical challenges of this practice. Thus, it is important that neurologists, neurosurgeons, and residents act collectively and in an integrated manner with other team members, sharing and reflecting collectively on their experiences in communicating difficult news [29].

When analyzing their experience in neurology and neurosurgery, participants mentioned challenges that permeate medical practice as a whole, reinforcing the idea that communicating difficult news involves multiple variables. A limitation of the study was the small sample size. However, the results provide important insights for achieving the proposed objectives. Thus, it is expected that new studies will improve subject analysis, enhancing the performance of neurologists, neurosurgeons, and residents who have chosen this field for training and medical practice.

Final considerations

Communicating difficult news in neuro-oncology requires more than technical expertise: it is a delicate moment that demands sensitivity. Although professionals recognize the responsibility involved, there are still significant challenges to overcome, as adopting a protocol can improve this communication. There is also the risk that the interaction will become mechanical and devoid of empathy. Therefore, it is essential that the physician finds a balance between following the methodology and acknowledging each patient's needs, respecting their emotions and reactions.

The study also demonstrated that clinical experience can be relevant in the communication process to family members. Therefore, continually revisiting the topic to improve outcomes in the physician-patient relationship is necessary, especially the communication of difficult news in the context of neurology and neurosurgery.

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Contribution of the authors (CRediT)

Ana Cristina Vidigal Soeiro guided the research process and participated in all stages, from the initial concept of the topic to the approval of the final manuscript. Ana Carolina de Castro Ribeiro Cabeça participated in data collection and final manuscript review. Giovana Pereira Lobato Brito, Maria Eduarda Cunha Elias, Eduardo Azevedo de Oliveira, Rebeca do Nascimento Pinto Lima, Wanessa de Barros Araújo and Sérgio Tibúrcio Segundo de Aguiar Silva participated in data collection and analysis, manuscript writing and final review.

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