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Professional communication practices in intensive care: a systematic review

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Abstract

Communication is fundamental when exchanging information and providing emotional support in healthcare contexts, especially in critical illnesses and palliative care. Empathy allows professionals to understand the needs of patients and family members, promoting respectful and continuous communication that takes into account the preferences discussed during treatment. However, many of those involved face difficulties in receiving and conveying clear information. Issues such as the use of technical jargon, insensitive approaches, and professional distress are common. Training and practices that prioritize empathy and clarity are essential, as is the action of healthcare professionals in accordance with the specific legal precepts of each country. This is a systematic review that analyzes the attitudes of healthcare professionals in communicating bad news in intensive care units, in different cultural and legal contexts, focusing on the perceptions of the multidisciplinary team.

Keywords: Hospital communication systems. Health communication. Psychology, medical. Health personnel. Professional-patient relations. Critical illness. Intensive care units.

Resumo

Práticas profissionais de comunicação em cuidados intensivos: revisão sistemática

A comunicação é crucial na troca de informações e no apoio emocional no contexto da saúde, especialmente em doenças críticas e cuidados paliativos. A empatia permite que profissionais compreendam as necessidades de pacientes e familiares, favorecendo uma comunicação respeitosa e contínua e que considere as preferências discutidas durante o tratamento. Entretanto, muitos dos envolvidos enfrentam dificuldades em receber e transmitir informações claras. Questões como uso de jargão técnico, abordagem insensível e sofrimento profissional são frequentes. Capacitação e práticas que priorizem empatia e clareza são fundamentais, assim como uma atuação dos profissionais de saúde em conformidade com os preceitos legais específicos de cada país. Este estudo consiste em uma revisão sistemática que analisa as atitudes dos profissionais de saúde na comunicação de más notícias em unidades de terapia intensiva, em diversos contextos culturais e jurídicos, com foco nas percepções da equipe multidisciplinar.

Palavras-chave: Sistemas de comunicação no hospital. Comunicação em saúde. Psicologia médica. Pessoal de saúde. Relações profissional-paciente. Estado terminal. Unidades de terapia intensiva.

Resumen

Prácticas profesionales de comunicación en cuidados intensivos: una revisión sistemática

La comunicación es fundamental para intercambiar informaciones y en el apoyo emocional en contextos de la salud, especialmente en enfermedades críticas y cuidados paliativos. La empatía permite a los profesionales comprender las necesidades de los pacientes y sus familiares, lo que favorece una comunicación respetuosa y continua que tiene en cuenta las preferencias discutidas durante el tratamiento. Sin embargo, muchos de los involucrados enfrentan dificultades para recibir y transmitir información clara. Son frecuentes cuestiones como el uso de jerga técnica, el enfoque insensible y el sufrimiento profesional. La capacitación y las prácticas que priorizan la empatía y la claridad son fundamentales, así como la actuación de los profesionales de la salud de conformidad con los preceptos legales específicos de cada país. Este estudio consiste en una revisión sistemática que analiza las actitudes de los profesionales de la salud en la comunicación de malas noticias en unidades de terapia intensiva, en diversos contextos culturales y jurídicos, centrándose en las percepciones del equipo multidisciplinario.

Palabras clave: Sistemas de comunicación en hospital. Comunicación en salud. Psicología médica. Personal de salud. Relaciones profesional-paciente. Enfermedad crítica. Unidades de cuidados intensivos.

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The authors declare no conflict of interest.

Communication is an essential element in informational and emotional exchanges between individuals and has a primary function in healthcare contexts, especially in interactions between professionals, patients, and family members [1]. Breaking bad news (BBN) in healthcare refers to conveying information that radically transforms a patient's prospect, which normally relates to diagnoses and management of serious illnesses [2]. BBN in intensive care units (ICU) causes anxiety in families, hence the need for effective communication by healthcare teams [1]. Scarce resources and lacking communication training can affect clinical practice [3].

Healthcare providers often view communication as a mere obligation and adopt indirect approaches in informational exchanges [4]. Bidirectional interaction is fundamental for effective communication, which must balance honesty and optimism. The intervention of the multidisciplinary team is crucial in emotional support for families [5], with family-centered care being vital to promote dignity and collaboration [6]. Also relevant is professional-targeted psychological support, which should include adaptation of work structures, self-care practices, meetings, and supervision [7].

Communication—improved by means of interaction and training—is essential to mitigate professional stress and increase patient satisfaction [4]. However, BBN training is still deficient, which results in patient dissatisfaction and emotional challenges faced by professionals [2,8]. Protocols have been established to guide this communication, such as SPIKES [8], PEWTER, and ABCDE, which have proven highly beneficial when implemented in training [4].

This systematic review aims to assess the role of healthcare professionals in BBN in ICU by analyzing the perceptions of professionals involved, the strategies employed, and the training necessary for such competence.

Method

The study objective was defined according to the SPIDER strategy [9], based on the following question: "What is the role of healthcare professionals and what are the perceptions of those involved in BBN in ICU?". A systematic review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) [10] guidelines, with registration in the International Prospective Register of Systematic Reviews (PROSPERO) under identification CRD42024612860.

The article search was performed on October 12, 2024, in the indexing databases: PubMed, Scopus, Web of Science, Lilacs, SciELO, and PsycINFO. We used a combination of terms related to "breaking bad news" and "intensive care." We filtered articles in English, Portuguese, and Spanish published since 2004: this time frame seeks to ensure the currency of the scientific debate with studies based on the SPIKES [8] protocol, whose subsequent influence standardized the communication of bad news and the training of health care professionals. Only original articles were included, i.e., review articles, book chapters, editorials, and conference proceedings were excluded. The exact search keys for each indexing database are presented in Chart 1.

Chart 1. Indexing database search keys

Indexing database	Key
Pubmed	(bad news deliver*) AND (ICU)
Scopus	(TITLE-ABS-KEY((bad AND news AND deliver*) AND TITLE-ABS-KEY((intensive AND care)))
Web of Science	Analyze Results: bad news deliver* (Topic) AND intensive care (Topic)
Lilacs	(terapia intensiva) AND (notícia*)
SciELO	(terapia intensiva) AND (notícia*)
psycINFO	Any Field: bad news AND ((Any Field: ICU) OR (Any Field: intensive care))

The articles were analyzed in the Rayyan [11] application, in order to eliminate duplicates. In the selection of articles for full-text reading, two reviewers (ASL/LMB) independently analyzed titles and abstracts and resolved any conflicts by consensus. We selected articles that analyze, discuss, or describe the professionals' perceptions of BBN in ICU. Articles involving only patient

and family perceptions were excluded. We also excluded: studies of patients and/or professionals outside the ICU; articles that do not address the communication of news in ICU; studies that exclusively address other aspects, such as the professionals' perceptions of patient and family suffering due to illness.

According to the same criteria, the three authors, divided into pairs and in independent analysis, selected the articles for review after full reading. Any conflicts were resolved by consensus among all authors. The articles included in the review were independently analyzed by the same pairs, with extraction of data, which were collected and managed in the REDCap application (Yale University) [12]. Any discrepancies were resolved by consensus by the pairs of reviewers.

For each study, we extracted the following information, when applicable: author; year and journal of publication; country where the study was conducted; study objectives, design, and methodology; type of ICU; number of study centers; professional involved in communication; number of participants; professionals' perception; authors' conclusions; and protocols applied in BBN.

The quantitative and qualitative results, including the perceptions and attitudes of health care professionals, were presented in a table or described and discussed in the body of the article. As this is secondary research with no subjects directly involved in the study, this work was not submitted for approval by a research ethics committee.

Results and discussion

Of the 201 potentially relevant titles and abstracts found in the indexing databases, 46 articles were selected for full reading, 20 of which were included in the systematic review (Figure 1). Chart 2 presents a description of the included articles.

From the 20 articles, we extracted 308 different items related to the health care professionals' perceptions and attitudes about BBN. The items were organized into six thematic groups, which are categorized and synthesized below.

Figure 1. PRISMA protocol-based search results

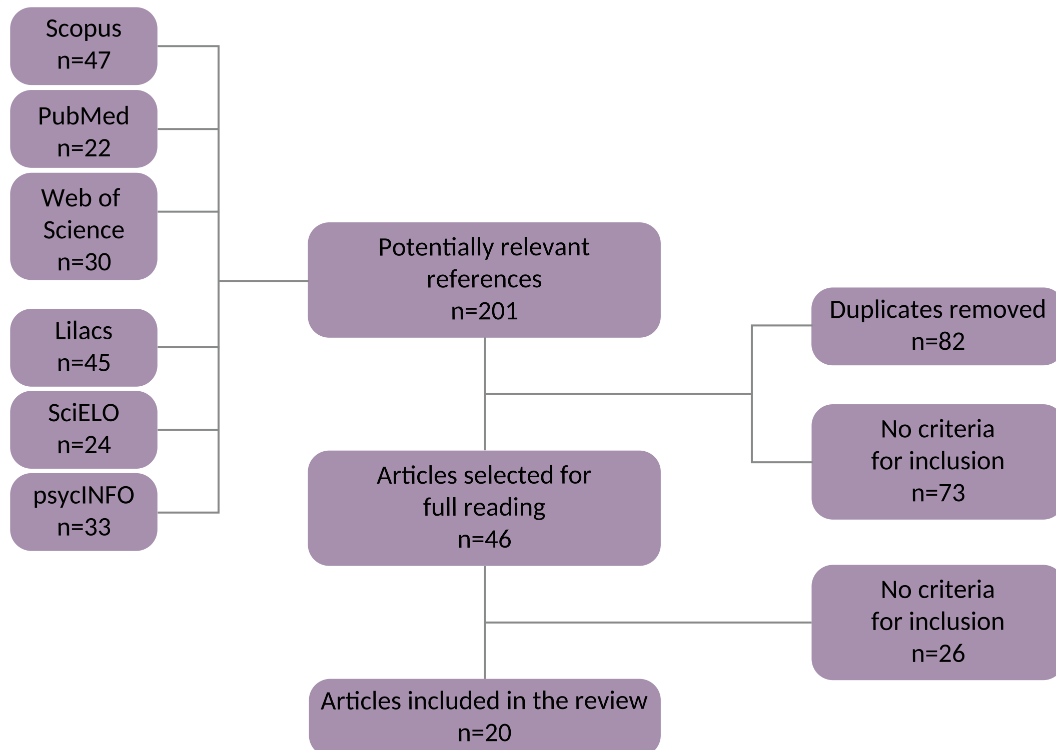

Chart 2. Characteristics of the included articles and main results

Authorship; year	Journal/country of study	Type of ICU (number of participating centers)	Professional involved in BBN (number of participating professionals)	Main results: perceptions and attitudes of professionals involved in BBN
Soeiro, Vasconcelos, Silva; 2022 [13]	*Revista Bioética*/ Brazil	Pediatric ICU (1)	Medical team (14)	The physicians noted the emotional impact of BBN in ICU, with ethical challenges such as maintaining hope while dealing with therapeutic limits and family reactions. They also reported a lack of formal training, with communication skills developed through practice.
Campos and collaborators; 2017 [14]	*Saúde em Debate*/Brazil	Neonatal ICU (1)	Multidisciplinary team (10)	The professionals reported a lack of preparation for BBN, which intensifies emotional suffering and promotes attitudes of detachment, mechanization, or insensitivity. They need humanization, emotional support, and training to deal with death and grief, in addition to better interdisciplinary integration.
Seifart and collaborators; 2022 [15]	*Frontiers in Pediatrics*/ Germany	Neonatal ICU (6)	Medical team (17)	BBN is considered a task that requires a sense of involvement and responsibility from healthcare professionals, negatively impacted by overload in clinical routine. The effectiveness of communication impacts the families' experiences during delicate moments.
Monteiro and collaborators; 2015 [16]	*Psicologia Argumento*/ Brazil	Adult ICU (1)	Medical team (6)	The presence of the family is considered essential in care during critical illness and at the end of life, to understand the patient and discuss clinical progression. Weakened, family members seek answers and safety, while the overloaded team prioritizes technical aspects. The physicians note the importance of empathy in BBN and respect for patient autonomy. In the relationship with family members, allow adequate time for adaptation to situations and for making informed decisions, ensuring patient- and family-centered care. The attending physician's follow-up can reduce conflicts with the family, but fragmentation among specialties can hinder integrated and patient-centered decision-making.

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Chart 2. Continuation

Authorship; year	Journal/country of study	Type of ICU (number of participating centers)	Professional involved in BBN (number of participating professionals)	Main results: perceptions and attitudes of professionals involved in BBN
Seoane and collaborators; 2012 [17]	*Ochsner Journal*/ United States	Adult ICU (1)	Resident physician (214)	In this study, at the end of their residency, the physicians still encounter difficulties in BBN, especially in discussing therapeutic limits and defining palliative care, noting the need for specific theoretical frameworks and clinical guidelines. Communication skills can be developed through training, with practical activities such as role-playing and simulations that improve communication among professionals, enabling enhanced interactions and providing better outcomes in intensive care.
Vale and collaborators; 2023 [18]	*Revista Latinoamericana de Bioética*/ Brazil	ICU (unspecified) (1)	Multidisciplinary team (29)	The professionals noted gaps in BBN training in undergraduate programs. They find even greater difficulty in communicating the death of young people. The participants exhibited evident apprehension as to the possible non-acceptance of the news by family members, making the communication process challenging.
Alves, Sarinho, Belian; 2023 [19]	*Revista Bioética*/ Brazil	Neonatal ICU (1)	Resident physician (12)	The residents reported that, in the ICU routine, physicians attribute little value to conversations with family members. They noted the lack of adequate space and insufficient time dedicated to clarifying doubts and discussing strategies and the relevance of specific training for BBN.
Haas, Brust-Renck; 2022 [20]	*Psicologia USP*/ Brazil	Adult ICU (unspecified)	Medical team (15)	The participants reported evolution in how they communicate compared to how they did it at the beginning of their careers, a result of professional and personal maturation. They noted that the time in professional practice makes the BBN process easier and they believe they are doing the best they can; however, they feel the challenge posed by BBN, with emotional and physical repercussions.

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Research

Chart 2. Continuation

Authorship; year	Journal/country of study	Type of ICU (number of participating centers)	Professional involved in BBN (number of participating professionals)	Main results: perceptions and attitudes of professionals involved in BBN
Camilo and collaborators; 2022 [21]	*Revista Gaúcha de Enfermagem*/ Brazil	Neonatal ICU (3)	Nursing team (17)	The participants' perceptions show the challenges in BBN, requiring that emotional support be offered to families, but they also emphasize structural and procedural difficulties and the burden of involvement with the suffering of relatives. Nursing work in multidisciplinary care helps promote bonds with family members, enabling nurses to play their role as caregivers during these difficult times, underscoring the importance of collaborative work within the team. They note cultural barriers, lack of training and self-protection of professionals in the face of the end of life.
Koch, Rosa, Bedin; 2017 [22]	*Revista Bioética*/ Brazil	Neonatal and pediatric ICU (1)	Multidisciplinary team (9)	The participants reported gaps in the training for BBN and the subjectivity related to the practice due to the lack of specific communication protocols. They noted the communication of death as the main challenge. They emphasized the importance of empathy, sincerity, and bond with the patient and family, with respect for religiosity.
Alves, Sarinho, Belian; 2023 [23]	*Saúde e Pesquisa*/Brazil	Neonatal ICU (1)	Medical team (12)	The study found challenges in BBN in ICU, showing structural problems, little empathy, work overload, and lack of adequate strategies. Training in a specific communication protocol helped resident physicians reflect on practices, reinforcing the importance of bonding, listening, empathy, and sensitivity when communicating, without affecting the hope of family members.
Souto, Schulze; 2019 [24]	*Revista Psicologia e Saúde*/Brazil	Neonatal ICU (1)	Unspecified professional (9)	Most participants proved unprepared for BBN, seeking intuitive and emotional resources, relying on accumulated experiences and the observation of more experienced teammates. The communication was considered a tense and emotionally draining task. The lack of formal protocols and training exacerbates the challenge, causing discomfort and emotional stress. Empathy was noted as an essential, albeit underdeveloped, skill, being fundamental in sensitive communication.

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Chart 2. Continuation

Authorship; year	Journal/country of study	Type of ICU (number of participating centers)	Professional involved in BBN (number of participating professionals)	Main results: perceptions and attitudes of professionals involved in BBN
Cabeça, Sousa; 2017 [25]	Revista de Pesquisa (Universidade Federal do Estado do Rio de Janeiro. Online)/ Brazil	Neonatal ICU (1)	Multidisciplinary team (14)	According to the study, professionals resort to empathy, personal experiences, and psychological support to deal with loss and suffering. Communication in the ICU requires empathy, clarity, active listening, and respect for family specificities. Strategies include gradual transmission, accessible language, care, collaboration, and emotional support for families, with assessment of prior understanding, psychological support, and careful, gradual dialogue. They note the importance of interdisciplinary work, sensitivity, and attention to non-verbal communication.
Monteiro and collaborators; 2015 [26]	*Estudos e Pesquisas em Psicologia*/Brazil	Adult ICU (1)	Medical team (12)	The participating physicians reported intense difficulty in communicating death, interpreting it as personal failure. The difficulty is even greater in the face of the death of young people, given the pain of their families. Communicating brain death is especially difficult for physicians, as it involves young patients, unexpected situations, and complex decision-making, such as organ donation. Physicians often avoid verbalizing the word "death," using euphemisms, possibly as an emotional defense mechanism.
October, Watson, Hinds; 2013 [27]	*Pediatric Critical Care Medicine*/ United States	Pediatric ICU (1)	Medical team (10)	In this study on the place chosen by physicians to interact with family members, it was found that physicians prefer to talk with family members in a conference room to discuss care redirection, but they prefer bedside communication for practicality, speed, or patient participation in the discussion. The need for ample space for a larger number of people was a factor associated with the physicians' preference for meeting with family members in a conference room.

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Chart 2. Continuation

Authorship; year	Journal/country of study	Type of ICU (number of participating centers)	Professional involved in BBN (number of participating professionals)	Main results: perceptions and attitudes of professionals involved in BBN
Berlacher and collaborators; 2017 [28]	*Journal of Palliative Medicine*/United States	Adult ICU (1)	Medical team (28)	This study addresses the results of a communication training geared toward physicians. It was observed that resident physicians were much more likely to report any previous training than the more experienced assistant professors. The perceived communicational preparedness increased in all skills after the training, even among experienced physicians, who would even recommend the training to their peers.
Ghoneim and collaborators; 2019 [29]	*Teaching and Learning in Medicine*/United States	Neonatal ICU (1)	Resident physician (15)	This study explores communication training in BBN for residents, which resulted in significantly improved scores in self-assessment and content tests. The need for continuous training in communication skills and the need for adaptation to different clinical experiences are noted.
Macdonell and collaborators; 2015 [30]	*Journal of Neonatal Nursing*/Canada	Neonatal ICU (1)	Unspecified professional (131)	The multidisciplinary team recognized the need for more training in BBN. The adoption of team and family meetings and practical training increased empathy, reflection, and partnership between professionals and families, promoting more humanized care and providing formal tools to improve communication in the ICU.
Monteiro, Quintana; 2016 [31]	*Psicologia: Teoria e Pesquisa*/Brazil	Adult ICU (1)	Medical team (12)	The professionals reported a lack of formal training in medical school, requiring learning through practice, observation, or common sense. The practice considered the observation of teachers, media examples, and subjective feelings as references. Some physicians seek emotion self-protection by adopting strategies such as vague language or euphemisms, which often affects clarity and causes discomfort in interactions with family members. BBN leads physicians to feel anguish, impotence, and guilt, especially when faced with patient or family suffering.

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Chart 2. Continuation

Authorship; year	Journal/country of study	Type of ICU (number of participating centers)	Professional involved in BBN (number of participating professionals)	Main results: perceptions and attitudes of professionals involved in BBN
Van Keer and collaborators; 2019 [32]	*Patient Education and Counseling*/ Belgium	Adult ICU (1)	Medical team (35)	This study explores BBN in ICU, who participates in conversations, considering teams, patients, and families. They observed that physicians communicate bad news mainly to family members, rarely involving patients. Difficulties arise from linguistic, cultural, and emotional barriers, in addition to family conflicts. It was found that nurses have limited participation in conversations. As a strategy to mitigate insufficient understanding by family members, they sought to simplify information, cooperate with teammates, and choose interlocutors among family members.

BBN: breaking bad news; ICU: intensive care unit.

Strategies and management

Interprofessional synergy is essential in the ICU, where collaboration has shown reduced mortality and improved quality of care [33]. The multidisciplinary team is fundamental for providing holistic patient care. Nurses, psychologists, social workers, and physical therapists have specialized profiles that contribute to the therapeutic plan and patient care. Different countries have specific legislations that regulate professional practice. In Brazil, acts directly associated with nosological diagnosis, determination of clinical prognosis, and definition of therapeutic conduct are restricted to medical practice [34], and other team members can participate as facilitators in the adoption of conducts prescribed by the physician or in educational and emotional support initiatives [35].

BBN requires technical preparation and ethical sensitivity, and physicians cannot transfer such responsibility to other team members [35,36]. However, the multidisciplinary team's work is essential to expand care and provide comprehensive, patient-centered support complementarily, without replacing physicians [35]. Physician skills are exclusive, but joint work with the multidisciplinary team enhances the quality of patient care [37].

Physicians often face insecurity in BBN, given the emphasis of their training on preserving life [18,26]. The communication of death, due to being primarily a task of physicians, can result in the health care team lacking co-responsibility in supporting family members [18]. Nursing work is crucial, as it fosters bonds with family members, enabling nurses to play their role as caregivers during these difficult times [21]. Physicians often seek the collaboration of other team members in difficult situations, which favors a caring environment [21,32].

Encouraged to participate in conversations, nurses and physical therapists contribute to improving communication with families and providing information about patient care [30]. The presence of psychologists and/or chaplains provides general support and is essential for improving communication and alleviating associated stress, helping patients and families find balance in critical times [16,32]. Psychological support helps professionals manage emotions and understand familial dynamics [13,16]. Co-responsibility among all is key for mitigating stress in BBN [13].

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BBN is complex and can involve family and friends, many of whom wish to participate in the conversations. However, including everyone is not always possible, and physicians must assess who is most able to understand the information and make decisions on behalf of the patient [32]. Choosing representatives is not always easy, as it is sometimes complicated by emotional, linguistic, and educational barriers [32]. Physicians generally include in conversations close family members who exhibit the ability to understand medical information. In situations of family disputes, it is important to include representatives from both sides to avoid conflicts and ensure balanced communication [32].

Whenever possible, the patient should be included in discussions about their treatment [36]. In the impossibility of doing so, the team must assess the wishes expressed by the patient in conjunction with the family [16]. In situations of difficult understanding, it is essential to include other family members to provide support and facilitate the interpretation of the news [25]. In the context of the neonatal ICU, meetings should be held with both parents in private settings, so communication is effective [30].

Meetings between professionals, patients, and families should be planned and are essential for decision-making, promoting comfort, facilitating understanding, and providing emotional support, in addition to improving treatment outcomes [38]. BBN should occur in private and relaxing settings [4]. However, the choice of setting is influenced by different factors, although it does not directly influence the outcome. Physicians prefer conference rooms, especially for discussing care redirection, such as transition to palliative care. Others choose bedside meetings for patient participation [27].

The effectiveness of BBN depends on the professionals' sensitivity and flexibility in adapting communication techniques to the patients' cultural context [39] and familial context [24]. Preparation for conversation, both from a technical and emotional standpoint, involves setting aside special time for communication and managing one's own feelings [26,31]. As a strategy, physicians initially question family members as to their knowledge about the patient's condition with open-ended questions, to check their prior understanding and perceived emotional states [25,32].

BBN is considered a task that requires a sense of involvement and responsibility from healthcare professionals [15]. Understanding and managing the factors that contribute to conversational difficulty leads to a more effective and satisfying experience for both the team and the family members [40]. Managing expectations is crucial, especially when curative treatment is not viable, and doctors should address the possibility of death with composure [13]. Suggestions include improving sensitivity, using religiosity as support, dedicating time for listening, and valuing humanization in care [14].

Communication should be gradual and adaptive [40] and respect the family's will to participate in decision-making [25]. Unfavorable news should not be communicated abruptly [13]. Whenever possible and relevant, professionals should involve relatives in the farewell process and allow them to participate in significant moments—for example, allowing the mother to hold her baby—if they wish, to facilitate grieving [25].

Humanized communication creates a caring environment and is essential for overcoming barriers. It should integrate verbal and non-verbal aspects, such as body language and emotions [16]. The effectiveness of communication influences family experiences during delicate moments [15]. Empathy is crucial in emotional management. Physicians must show availability and support, in addition to openness for accommodating family decisions as needed [16].

Empathy is considered an essential skill in BBN, which can be learned and developed [19,24]. Providing "a word of affection" and emotional support is fundamental for valuing families during the process [21]. Empathetic communication promotes co-responsibility and participation in treatment, which are essential for the well-being of everyone involved [16].

Compassionate approaches include complete explanations and supportive information, which help families feel well-informed [30]. Clarity and honesty are essential to enable families to make decisions. Professionals must explain the pathology, treatment options, and prognosis in a direct and

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realistic manner [16,32]. Despite adversities, honest and caring dialogue facilitates understanding and creates an environment of emotional support [13]. Communication must be clear, without aggression [25], based on a bilateral exchange marked by equality and respect [3], in order to enable family members to understand the seriousness of the situation and make informed decisions. Guiding access to external information, when requested, and adopting an optimistic approach helps families cope with such a difficult period [5].

Emotional aspects of professionals

BBN causes significant anxiety in both the sender and receiver of information, which shows the complexity of this interaction [22]. The factors that contribute to make conversations difficult can be related to the physician, the patient, the situation, or a combination of them [40]. Breaking bad news can have a significant emotional impact on the physician, who often feels the burden of this negative information and anticipates negative reactions [41]. Professionals experience anticipatory stress, which results in physical symptoms such as increased heart rate and anxiety [1,13], reflecting the emotional burden of the work [14]. All team members face considerable distress due to patient pain. Manifest crying during conversations, anxiety, depression, and burnout syndrome are common among professionals [22].

Humanized care projects often do not include emotional support for professionals [14]. Family despair exacerbates the emotional stress of professionals [26], who need to deal with pain and death, developing feelings of fragility and vulnerability, which are not always shared [25].

The unpredictability of the conversations increases anguish and impacts the professionals' personal life and confidence, leading them to adopt emotional detachment strategies, which cause conflicts between care and self-preservation [7]. Although professionals believe they are doing the best they can, they feel the emotional and physical burden of BBN [20]. The tension between empathy and technical capacity makes emotion a problem, not a tool [14]. The pressure for infallibility and the lack of support contribute to unrecognized stress and a feeling of isolation [7].

Professionals who develop closer bonds with patients, such as in pediatric oncology, experience especially intense emotional reactions in situations of loss [13,26]. Often, the death is associated with feelings of guilt and failure [14,26] and its communication is considered an uncomfortable task for the physician. Death—not directly mentioned—is replaced with other expressions and not rarely with euphemisms, which precludes clear and empathetic communication [26]. Its communication is often seen by physicians as a difficult and uncomfortable task [26]. The conflict between the mission to save lives and the inevitability of death [26], associated with the recognition of one's own limits, leads physicians to adopt defense mechanisms, such as emotional detachment from patients and families and manifest coldness [14].

Some professionals choose not to be present during BBN to avoid the emotional impact [14], while others suppress emotions during the conversations, resulting in formal and distant dialogues [24]. Prioritizing technical resources over emotional expression exacerbates the detachment from the patient and family suffering and the emotional distance, further hindering communication [16].

The belief that BBN should be carried out by professionals that are more resilient or in superior positions [31] reaffirms the lack of training [14]. To cope with suffering, some resort to psychological support [13,25]. Others sustain themselves with family support and religious practices [13].

Relationship with patients and families

Proper attention in the communication process makes family members feel safer and more confident [16,19] and favors collaboration and acceptance of the clinical situation, which facilitates medical work [16]. BBN must be transparent to establish a strong bond with the family, which is essential for conveying challenging information [13], with questions aimed at understanding the family's feelings before communicating the news [31], thus providing the necessary time and privacy for complete and compassionate discussions. Getting closer to the "world of the other" implies understanding the psychological and imaginary aspects of the families, which have distinct realities

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and experiences. Proficiency in BBN is fundamental for patient-centered care, as it influences the patient's understanding and adaptation [42] and optimizes choices in complex decision-making [16,30].

The use of technical language and lack of empathy during conversations cause dissatisfaction to families of patients in the ICU [1]. The excessive use of technical jargon makes it difficult to understand essential information about the clinical situation [13]. Some professionals use strictly objective, data-focused communication, which can result in emotional detachment [31]. Patients and families want honest information, but they expect that the professionals respect their assimilation process, so they consider frank communication potentially stressful [43]. Clear communication, with accessible examples and respect for the patient's unique characteristics, such as cultural and social context [44], fosters more empathetic and caring understanding, emotional comfort for family members, and more participation in the treatment [16,25,32].

Healthcare professionals must respect and recognize as legitimate the emotional reactions and feelings of families of critically ill patients [16]. Several professionals expect families to quickly accept the patient's critical condition, ignoring the complicated emotional process they face [16]. However, they must provide technical clarification, emotional support, and spiritual support [25], with openness to the family's concerns and fears. Furthermore, they should understand that different members of the same family may react in distinct ways [31] and, in delicate situations, remain calm and request composure from those involved, with a view to promoting constructive dialogues and strengthening bonds [32].

Communication with family members should be carried out on a daily basis and contain information about the patient's health status, in order to prepare them for potential difficult news and reduce the impact of unexpected information [25]. It is important to have a reference physician, that is, to avoid rotating professionals. This continuity reduces the feeling of loneliness and provides confidence, emotional support, and security [25]. It is necessary to train communication skills to provide more effective and empathetic service [25]. Although caregiving activities are time-consuming and hinder communication, there should be investment in attentive listening, as it alleviates suffering and helps understand the family members' needs as it respects concerns and resolves doubts [16,44].

In critical situations, professionals use non-verbal communication, such as hugs and touches, to provide emotional support and show recognition of the suffering of family members [44]. Attentive gaze and expressive gestures promote effective interaction [1,26] and create a space of trust [25].

Barriers and challenges

BBN in ICU is complex and challenging. Hindering situational factors include time pressures during care, conflicts between patients and team, or complex social issues [40]. The professionals already have a heavy clinical routine [15], with little availability for conversation due to overload in the work setting [16,45]. Communication often involves a sedated or intubated patient [13], being an emotionally charged task, especially in case of unexpected events [13,22]. It is seen as an unpleasant task for both the communicator and the receiver [24]. As it is a painful and traumatic event, BBN can cause a detachment between professionals and family members, thereby affecting the therapeutic relationship [13,16,32]. The management of personal and interpersonal skills is of utmost importance for the interaction with families of critical patients. Professionals must be prepared to deal with technical, ethical, legal, and relational aspects [13].

A systematic review of 40 studies with 3,242 participants showed that healthcare professionals often perceive communication as a mere obligation and adopt indirect approaches when communicating [4]. Professionals tend to talk more and ask few questions to family members, without discussing the patient's perspective, establishing a little comprehensive communication [32].

Many professionals avoid directly communicating the severity of the clinical condition and use ambiguous expressions, which lead to uncertainty in family members [31]. Even when communicating death, albeit expected, physicians hesitate to use the word "death," which reflects a denial of life's finitude, and resort to euphemisms [26]. By denying death through the choice of softer words, professionals face the inevitability of

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finitude without having to deal directly with pain [26]. The lack of clarity in the information affects the family members' perception and can lead to false expectations [26] and communication failures [31].

The healthcare team must adapt its communicational approach to the cultural needs [44] and preferences of family members, since effective communication strengthens the family bond and reduces stress [5]. BBN becomes even more challenging when there are linguistic barriers, especially if there is a need to employ interpreters, who do not always produce accurate translations [32]. Family members with communicational difficulties are not seen as adequate interlocutors in conversations, and ethnocultural contexts can further complicate discussions [32].

Another challenge is the family members' lack of understanding as to the severity of the critical patient's condition, which requires professionals to have sensitivity and multiple interactions to increase comprehension [16,32]. Denial is a common reaction to BBN and results in the need to repeat information [13]. The complexity of critical illness and the expectation of a "miracle" make understanding difficult, especially in socially vulnerable populations [16].

The professionals' excessive workload, lack of time, and inadequate infrastructure compromise the communication of sensitive news [14], hinder the clarification of doubts and hamper discussions about care [19], further affecting the interaction between professionals and families [21]. Conversations about bad news often occur at the bedside or in inappropriate spaces, such as the hallway [21], which causes discomfort and resistance in family members, who feel exposed [32], thus hindering the effectiveness of communication and affecting the understanding of the news.

Conflicts between family members and disagreements between patient will and family will make consensual decision-making difficult and compound the challenge for physicians. Financial issues and frustration feelings, especially among those who after long periods of estrangement try to obtain redemption at the time of a family member's illness, affect people's behavior, thus intensifying tensions in interactions [16].

In the event of conflicts and in order to understand the family's needs, it is essential that professionals approach the subjective world of family members and recognize the uniqueness of each familial system [44]. This understanding facilitates communication and promotes more humanized care [16].

Physicians report breaking news of clinical deterioration and death as the most challenging conversations [22]. Communicating death is noted as the most difficult situation, and physicians underscore the association between death and the perception of "bad news" [26]. In an interview on the issue, professionals associated the difficulty in BBN with patient age and noted that they face difficulties in associating the end of life with young individuals [18,26]. The news of child death, an event that defies the natural order of expectations, and the communication of brain death in previously not ill young people, that is, whose lives are abruptly interrupted [26] are examples of difficult situations for both families and professionals.

Training, professional development, and tools

BBN is part of healthcare professionals' routine, but many still feel unprepared for the task. Several physicians express difficulties in conveying this information appropriately and often get emotional with patients and families [24]. Despite theoretical and practical knowledge, physicians generally feel unprepared to communicate death, without knowing the best approach for the situation. This lack of preparation is recurrent, as shown by one of the studies in the review, in which physicians, when invited to participate in the research, reported a need for change in how they communicate bad news [31].

The lack of specific training to deal with death makes communication even more challenging [45]. Although some physicians feel capable, the theoretical training—scarce during undergraduate programs [46]—does not guarantee security in practice [14,18,24,26,31]. This gap results in approaches based on personal experiences and in confusing or rude messages [24]. In medical practice, BBN is not sustained by formal technique, but is informed by the personal experiences and intuitions of physicians [31], with improvised approaches adapted to the needs of the situation, without

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a previously established strategy [32]. The BBN practice is characterized by empirical and informal knowledge [22]; thus, professionals act according to their own perceptions, conceptions, and experiences [24]. The perception as to the need to develop communicational skills generally arises only in practice, so physicians devise empirical strategies [14].

The lack of specific protocols and theoretical frameworks is frequently reported, and several professionals suggest that structured techniques could improve patient understanding [24]. Experience in BBN is generally acquired through practice, direct experimentation, or observation of more experienced professionals [24]. The professor is seen as an essential reference when developing the skill, although BBN is not perceived as a formally taught technique, but rather predominantly learned in practice and by observation [31].

Participants in a study included in this review noted a significant change in their communicational approaches throughout their careers, which was attributed to personal and professional maturation [20]. In another study, an interviewed resident noted that their first experience was traumatizing and that prior training would have been useful [19]. Almost all professionals indicate the urgency of better training in the area. Macdonell and collaborators [30] report that, among physicians, even when self-declaring as experienced, 88% agreed on the need for more training. Residents, interns, social workers, and nurses also expressed the need for more preparation [30].

BBN requires a theoretical framework and specific clinical guidelines, and its skills can be developed through training [46], including practical activities such as role-playing and simulations, which improve communication among professionals [4,47] and, consequently, interactions and outcomes in intensive care [4,5,17].

A workshop was held to train residents and physicians in BBN, and 100% of the attending physicians recommended that this training be mandatory for ICU teammates and residents [28]. Among residents, 95% recommended the training as a requirement. In another study, Ghoneim and collaborators [29] observed significant improvements after training [29].

The SPIKES protocol [8,42], with its six structured steps, emphasizes the need to involve the family, create an appropriate environment, practice empathy, and develop a clear care plan [1,14,23]. An appropriate environment should be provided for sensitive communication, which includes, among other things, choosing the setting for the conversation [45]. The SPIKES protocol has been effective in training residents in BBN [42]. Other protocols, such as EMPATHY, emphasize the importance of accessible language and patient right to truth and clarification for decision-making [1].

Ethical, legal, cultural, and religious aspects. And hope...

According to Brazilian legislation, determining the prognosis related to a nosological diagnosis is an exclusive activity of physicians [37], meaning that only physicians have the technical and legal authority to establish predictions about the course of a patient's health condition, based on the diagnosis obtained through clinical evaluation and complementary exams. A Federal Council of Medicine (CFM) resolution [35] reinforces that physicians are exclusively responsible for reviewing therapeutic strategies and defining conducts according to diagnosis. The Code of Medical Ethics [36], in turn, determines that omitting the diagnosis and prognosis is forbidden for physicians, except in situations where direct communication may cause harm to patients. In these cases, the law establishes that such information must be transmitted to the individual's legal representative.

Physicians are responsible for providing objective information and sharing the seriousness of the situation in a clear and realistic manner, explaining the risks and allowing the family to follow the patient's condition. There are ethical and medical legal implications in breaking bad news, which means that withholding vital information on the patient diagnosis and prognosis based on the assumption that they will not be able to "cope with" this information may not always be justifiable, given patient autonomy and "right to know" [36,41]. The participation of family members in understanding the clinical situation strengthens the alliance with the healthcare team [44] and promotes better understanding and cooperation [16].

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In some situations, family members ask that the patient is not to be communicated bad news, either for fearing they may lose hope or for cultural reasons [39]. However, conscious patients have the right to know their condition, thus respecting their autonomy [32]. Physicians have the ethical duty to communicate information to the patient—both good and bad information. Respect for truth and transparency are fundamental principles in medical practice [13,32]. When the patient has the capacity to express their will, their decision must prevail [16].

The family's lack of understanding often challenges the professional communicating bad news. People often do not accept a negative diagnosis due to certainty in curative treatments and interpretations based on ethnoreligious beliefs [32]. Spirituality and religiosity profoundly influence treatment as they provide hope and inform the expectations of family members, who may believe in divine interventions until the very last moment [13,16]. Faith and religion often interfere with medical decisions, and there are families who believe that the physician is merely an instrument of God and that efforts should be maintained until a miracle occurs. This view can lead to conflict between family expectations and the limitations imposed by the patient's clinical condition [16], although beliefs can also sometimes aid in accepting the situation [13].

"Hope" emerges as an ethical imperative in medical practice, and its recognition is fundamental for communication and care. Maintaining hope is crucial for facing difficulties, as it provides an optimistic perspective that favors the process of acceptance, even in severe clinical cases. Physician must manage the ethical dilemma of balancing honesty about the clinical condition and preserving the family's hope [13].

Addressing hope is especially challenging for a physician when they have already lost optimistic expectations, which affects the communication with the family [13,16]. They are responsible for communicating the prognosis realistically but hopefully. In the study of Alves, Sarinho, and Belian [23], the major difficulty noted by the participating resident physicians was communicating the prognosis realistically without losing hope. However, training can develop such skill, which underscores the importance of emotional support in clinical practice [14,23].

Study limitations and strengths

This systematic review has some limitations. Initially, it is not possible to know if the professionals' predominantly negative perceptions on the experiences of breaking bad news could indicate a focus, during data collection, on the difficulties of the task or a subjective bias due to preconceptions. The small sample sizes in a considerable proportion of the reviewed studies may have limited the spectrum of experiences reflected in the data and the insights obtained in the synthesis. Most studies did not include the specialization level of the healthcare professionals in palliative care and intensive care, which hinders the analysis of the added value of the specialization. Another limitation of the study is not having analyzed how the legal and juridical context of each country influences the roles of healthcare professionals. Normative aspects determine to varying degrees the responsibilities and participation of the multidisciplinary team in communication with families and can introduce biases in the understanding of these dynamics in different healthcare systems. Regarding BBN training, it is still insufficient the understanding of the "ceiling effect" during training, according to which professionals with prior training may react differently. There was no analysis of patient satisfaction and outcomes, nor of the mental and physical health of patients and families. A noted strength of this review is the employed strategy of comprehensively searching reputable indexing databases to select articles that are relevant to the research objectives, with approaches and impressions from professionals from diverse countries and, therefore, with major ethnocultural diversity.

Final considerations

The role of healthcare professionals in BBN in ICU is to provide clear and honest information, with empathy and respect for the family and their feelings. They should adapt the language

to the family members' level of understanding, avoiding jargon and minimizing emotional impact. Communication must be continuous and address technical and emotional aspects of care, while respecting cultural particularities and individual reactions. It is essential that professionals conduct a prior assessment of the family members' knowledge, expectations, and emotional conditions.

An exacerbated level of anguish was observed among professionals, resulting from insufficient academic training and continuing education. Implementing specific training for ICU professionals is relevant for increasing the quality of care and mitigating adverse repercussions, especially regarding the emotional well-being of those involved. Developing skills such as empathy is essential and there should be continuous improvement through specific communication training, using tools such as the SPIKES protocol for more effective and humanized conversations.

The professionals' preparation should include time to organize technical aspects and manage their own emotional state, in order to ensure a balanced approach. Healthcare professionals should implement strategies that foster humanization and interprofessional collaboration during BBN. It is recommended the careful selection of the family member involved in the communication, prioritizing those with a greater capacity to understand clinical information and make decisions representing the patient. The meetings should be held in private and suitable settings, in order to provide comfort, emotional support, and an appropriate atmosphere for dialogue.

BBN should be guided by the bioethical principles of autonomy, beneficence, non-maleficence, and justice, in order to guarantee that patient and family are provided clear, truthful, and comprehension-appropriate information, respect for personal and cultural values, and preservation of dignity at all stages of care.

References

1. Marçola L, Zoboli I, Polastrini RTV, Barbosa SMM. Comunicação de más notícias em uma unidade de terapia intensiva neonatal: a avaliação feita pelos pais. Rev Paul Pediatr [Internet]. 2020 [acesso 14 mar 2025];38:1-6. DOI: 10.1590/1984-0462/2020/38/2019092
2. Cardoso AF, Rosendo I, Santiago L, Neto J, Cardoso D. Protocols for breaking bad news in health care: a scoping review protocol. JBI Evidence Synthesis [Internet]. 2024 [acesso 16 mar 2025];22(11):2411-8. DOI: 10.11124/JBIES-23-00404
3. Evangelista VC, Domingos TS, Siqueira FPC, Braga EM. Equipe multiprofissional de terapia intensiva: humanização e fragmentação do processo de trabalho. Rev Bras Enferm [Internet]. 2016 [acesso 15 mar 2025];69(6):1037-44. DOI: 10.1590/0034-7167-2016-0221
4. Jalali R, Jalali A, Jalilian M. Breaking bad news in medical services: a comprehensive systematic review. Heliyon [Internet]. 2023 [acesso 16 mar 2025];9(4):e14734. DOI: 10.1016/j.heliyon.2023.e14734
5. Guttmann KF, Raviv GN, Fortney CA, Ramirez M, Smith CB. Parent perspectives on communication quality in the neonatal intensive care unit. Adv Neonatal Care [Internet]. 2024 [acesso 15 mar 2025];24(4):382-88. DOI: 10.1097/ANC.0000000000001178
6. Maatman SMO, Bohlin K, Lilliesköld S, Garberg HT, Uitewaal-Poslawky I, Kars MC, van den Hoogen A. Factors influencing implementation of family-centered care in a neonatal intensive care unit. Front Pediatr [Internet]. 2020 [acesso 14 mar 2025];8:222. DOI: 10.3389/FPED.2020.00222
7. Francis L, Robertson N. Healthcare practitioners' experiences of breaking bad news: a critical interpretative meta synthesis. Patient Educ Couns [Internet]. 2023 [acesso 16 mar 2025];107. DOI: 10.1016/j.pec.2022.107574
8. Baile WF. SPIKES – A six-step protocol for delivering bad news: application to the patient with cancer. Oncologist [Internet]. 2000 [acesso 24 ago 2025];5(4):302-11. DOI: 10.1634/theoncologist.5-4-302
9. Cooke A, Smith D, Booth A. Beyond PICO: the SPIDER tool for qualitative evidence synthesis. Qual Health Res [Internet]. 2012 [acesso 16 mar 2025];22(10):1435-43. DOI: 10.1177/1049732312452938

10. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD *et al*. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ [Internet]. 2021 [acesso 16 mar 2025];372(71). DOI: 10.1136/BMJ.N71.1
11. Ouzzani M, Hammady H, Fedorowicz Z, Elmagarmid A. Rayyan: a web and mobile app for systematic reviews. Syst Rev [Internet]. 2016 [acesso 14 mar 2025];5(1):2-10. DOI: 10.1186/s13643-016-0384-4
12. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture (REDCap): a metadata-driven methodology and workflow process for providing translational research informatics support. J Biomed Inform [Internet]. 2009 [acesso 16 mar 2025];42(2):377-81. DOI: 10.1016/j.jbi.2008.08.010
13. Soeiro ACV, Vasconcelos VCS, Silva JAC. Desafios na comunicação de más notícias em unidade de terapia intensiva pediátrica. Rev. bioét. (Impr.) [Internet]. 2022 [acesso 16 mar 2025];30(1):45-53. DOI: 10.1590/198380422022301505PT
14. Campos CACA, Silva LB, Bernardes JS, Soares ALC, Ferreira SMS. Desafios da comunicação em unidade de terapia intensiva neonatal para profissionais e usuários. Saúde Debate [Internet]. 2017 [acesso 16 mar 2025];41(2):165-74. DOI: 10.1590/0103-11042017S214
15. Seifart C, Falch M, Wege M, Maier RF, Carrasco AJP. NEO-SPEAK: a conceptual framework that underpins breaking bad news in neonatology. Front Pediatr [Internet]. 2022 [acesso 14 mar 2025];10. DOI: 10.3389/fped.2022.1044210
16. Monteiro MC, Magalhães AS, Féres-Carneiro T, Machado RN. A relação médico-família diante da terminalidade em UTI. Psicol argum [Internet] 2015 [acesso 15 mar 2025];33(81):314-29. DOI: 10.7213/psicol.argum.33.081.AO07
17. Seoane L, Bourgeois DA, Blais CM, Rome RB, Luminais HH, Taylor DE. Teaching palliative care in the intensive care unit: how to break the news. Ochsner Journal [Internet]. 2012 [acesso 16 mar 2025];12(4):312-7. Disponível: https://bit.ly/4qOaimF
18. Vale IS, Mota VBR, Leitão IES, Barros BFM, Pasklan ANP, Lima SF. Comunicação de notícias difíceis: investigação dos conhecimentos de profissionais que trabalham em unidade de terapia intensiva. Rev Latinoam Bioét [Internet]. 2023 [acesso 16 mar 2025];23(2):59-70. DOI: 10.18359/rlbi.6379
19. Alves CAC, Sarinho SW, Belian RB. Comunicação de más notícias em unidade de terapia intensiva neonatal. Rev. bioét. (Impr.) [Internet]. 2023 [acesso 14 mar 2025];31(2):1-8. DOI: 10.1590/1983-803420233448PT
20. Haas KDC, Brust-Renck PG. A comunicação de más notícias em unidade de terapia intensiva: um estudo qualitativo com médicos experientes e novatos. Psicologia USP [Internet]. 2022 [acesso 16 mar 2025];33. DOI: 10.1590/0103-6564e220006
21. Camilo BHN, Serafim TC, Salim NR, Andreato AMO, Roveri JR, Misko MD. Comunicação de más notícias no contexto dos cuidados paliativos neonatal: experiência de enfermeiros intensivistas. Rev Gaúcha Enferm [Internet]. 2022 [acesso 15 mar 2025];43. DOI: 10.1590/1983-1447.2022.20210040
22. Koch CL, Rosa AB, Bedin SC. Más notícias: significados atribuídos na prática assistencial neonatal/pediátrica. Rev. bioét. (Impr.) [Internet]. 2017 [acesso 14 mar 2025];25(3):577-84. DOI: 10.1590/1983-80422017253214
23. Alves CAC, Sarinho SW, Belian RB. Vídeo educativo participativo para humanização da assistência em saúde. Saúde Pesq [Internet]. 2023 [acesso 14 mar 2025];16(2). DOI: 10.17765/2176-9206.2023v16n2.e11320
24. Souto DC, Schulze MD. Profissionais de saúde e comunicação de más notícias: experiências de uma unidade neonatal. Rev Psicol Saúde [Internet]. 2019 [acesso 14 mar 2025];11(3):173-84. DOI: 10.20435/pssa.v0i0.690
25. Cabeça LPF, Sousa FGM. Dimensões qualificadoras para a comunicação de notícias difíceis na unidade de terapia intensiva neonatal. Rev Pesqui [Internet]. 2017 [acesso 16 mar 2025];9(1):37-50. DOI: 10.9789/2175-5361.2017.v9i1.37-50
26. Monteiro DT, Reis CGC, Quintana AM, Mendes JMR. Morte: o difícil desfecho a ser comunicado pelos médicos. Estud Pesqui Psicol [Internet]. 2015 [acesso 16 mar 2025];15(2):547-67. Disponível: https://bit.ly/4bqFfc6
27. October TW, Watson AC, Hinds PS. Characteristics of family conferences at the bedside versus the conference room in pediatric critical care. Pediatr Crit Care Med [Internet]. 2013 [acesso 14 mar 2025];14(3):135-42. DOI: 10.1097/PCC.0b013e318272048d
28. Berlacher K, Arnold RM, Reitschuler-Cross E, Teuteberg J, Teuteberg W. The impact of communication skills training on cardiology fellows' and attending physicians' perceived comfort with difficult conversations. J Palliat Med [Internet]. 2017 [acesso 15 mar 2025];20(7):767-9. DOI: 10.1089/jpm.2016.0509

29. Ghoneim N, Dariya V, Guffey D, Minard CG, Frugé E, Harris LL *et al*. Teaching NICU Fellows How to Relay Difficult News Using a Simulation-Based Curriculum: Does Comfort Lead to Competence? Teach Learn Med [Internet]. 2019 [acesso 14 mar 2025];31(2):207-21. DOI: 10.1080/10401334.2018.1490649
30. Macdonell K, Omrin D, Pytlik K, Pezzullo S, Bracht M, Diambomba Y. An effective communication initiative: using parents' experiences to improve the delivery of difficult news in the NICU. J Neonatal Nurs [Internet]. 2015 [acesso 14 mar 2025];21(4):142-9. DOI: 10.1016/j.jnn.2015.01.002
31. Monteiro D, Quintana A. A comunicação de más notícias na UTI: perspectiva dos médicos. Psic: Teor e Pesq [Internet]. 2016 [acesso 16 mar 2025];32(4):1-9. DOI: 10.1590/0102.3772e324221
32. Van Keer RL, Deschepper R, Huyghens L, Bilsen J. Challenges in delivering bad news in a multi-ethnic intensive care unit: an ethnographic study. Patient Educ Couns [Internet]. 2019 [acesso 15 mar 2025];102(12):2199-207. DOI: 10.1016/j.pec.2019.06.017
33. Xyrichis A, Rose L. Interprofessional collaboration in the intensive care unit: power sharing is key (but are we up to it?). Intensive Crit Care Nurs [Internet]. 2024 [acesso 15 mar 2025];80. DOI: 10.1016/j.iccn.2023.103536
34. Pazinatto MM. A relação médico-paciente na perspectiva da Recomendação CFM1/2016. Rev. bioét. (Impr.) [Internet]. 2019 [acesso 24 ago 2024];27(2):234-43. DOI: 10.1590/1983-80422019272305)
35. Conselho Federal de Medicina. Resolução CFM nº 2.416, de 19 de setembro de 2024. Dispõe sobre os atos próprios dos médicos, sua autonomia, limites, responsabilidade e juridicidade. Diário Oficial da União [Internet]. Brasília, p. 587324003, 19 set 2024 [acesso 23 ago 2025]. Disponível: https://bit.ly/4pCLb5j
36. Conselho Federal de Medicina. Resolução CFM nº 2.217, de 27 de setembro de 2018. Aprova o Código de Ética Médica. Diário Oficial da União [Internet]. Brasília, p. 179, 1º nov 2018 [acesso 23 ago 2025]. Disponível: https://bit.ly/2RyvAE8
37. Brasil. Lei nº 12.842, de 10 de julho de 2013. Dispõe sobre o exercício da Medicina. Diário Oficial da União [Internet]. Brasília, p. 1, 11 jul 2013 [acesso 23 ago 2025]. Disponível: https://bit.ly/3NBBBSJ
38. Glajchen M, Goehring A, Johns H, Portenoy RK. Family meetings in palliative care: benefits and barriers. Curr Treat Options Oncol [Internet]. 2022 [acesso 16 mar 2025];23(5):658-67. DOI: 10.1007/s11864-022-00957-1
39. Holmes SN, Illing J. Breaking bad news: tackling cultural dilemmas. BMJ Support Palliat Care [Internet]. 2021 [acesso 27 ago 2025];11:128-32. DOI: 10.1136/bmjspcare-2020-002700
40. Lorenzetti RC, Jacques CHM, Donovan C, Cottrell S, Buck J. Managing difficult encounters: understanding physician, patient, and situational factors. Am Fam Physician [Internet]. 2013 [acesso 27 ago 2025];87(6):419-25. Disponível: https://bit.ly/3L8bB0N
41. Kumar V, Sarkhel S. Clinical practice guidelines on breaking bad news. Indian J Psychiatry [Internet]. 2023 [acesso 27 ago 2025];65(2):238-44. DOI: 10.4103/indianjpsychiatry.indianjpsychiatry_498_22
42. Mahendiran M, Yeung H, Rossi S, Khosravani H, Perri GA. Evaluating the effectiveness of the SPIKES model to break bad news – a systematic review. Am J Hosp Palliat Care [Internet]. 2023 [acesso 15 mar 2025];40(11):1231-60. DOI: 10.1177/10499091221146296
43. Engel M, Kars MC, Teunissen S, van der Heide A. Effective communication in palliative care from the perspectives of patients and relatives: a systematic review. Palliat Support Care [acesso 16 mar 2025]. 2023 [Internet];21(5):890-913. DOI: 10.1017/S1478951523001165
44. Patient-centred communication [Internet]. Ottawa: Canadian Medical Protective Association; 2021 [acesso 23 ago 2025]. Disponível: https://bit.ly/3NDE1Ag
45. Oliveira S, Lisboa W. Comunicação de notícias difíceis no contexto brasileiro: revisão de escopo. Rev. bioét. (Impr.) [Internet]. 2025 [acesso 27 ago 2025];33:1-13. DOI: 10.1590/1983-803420253785PT
46. Pinheiro RGX, Carneiro LFP, Melo AGAC, Oliveira FO, Moratto MA, Barra WF. Comunicação de más notícias: uma necessidade negligenciada? Rev. bioét. (Impr.) [Internet]. 2025 [acesso 27 ago 2025];33:1-8. DOI: 10.1590/1983-803420253811PT
47. Camargo NC, Lima MG, Brietzke E, Mucci S, Góis AFT. Teaching how to deliver bad news: a systematic review. Rev. bioét. (Impr.) [Internet]. 2019 [acesso 15 mar 2025];27(2):326-40. DOI: 10.1590/1983-80422019272317

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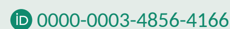 0000-0003-4856-4166

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