DOI: 10.20514/2226-6704-2021-12-2-136-142 УДК 614.253

А.А. Маркова*[1], М.И. Барсукова[2]

[1]— ФГБОУ ВО «Саратовский государственный медицинский университет» им. В.И. Разумовского Минздрава России, кафедра госпитальной терапии лечебного факультета, Саратов, Россия
[2]— ФГБОУ ВО «Саратовский государственный медицинский университет» им. В.И. Разумовского Минздрава России, кафедра педагогики, образовательных технологий и профессиональной коммуникации, Саратов, Россия

ТАКТИКА СООБЩЕНИЯ ПЛОХИХ НОВОСТЕЙ В ПРОФЕССИОНАЛЬНОМ ОБЩЕНИИ ВРАЧА И ПАЦИЕНТА

A.A. Markova*[1], M.I. Barsukova[2]

[1]— Saratov State Medical University named after V.I. Razumovsky, Ministry of Health of Russian Federation, Department of the Internal Medicine, Saratov, Russian Federation
[2]— Saratov State Medical University named after V.I. Razumovsky, Ministry of Health of Russian Federation, Department of Pedagogics, Educational Technologies and Professional Communication, Saratov, Russian Federation

Tactics of Reporting Bad News in Professional Communication Between a Doctor and a Patient

Резюме

Статья посвящена развитию уровня коммуникативной компетентности будущих врачей и особенностям профессионального общения с пациентами. Основанием работы стали вопросы определения речевого поведения врача в одной из самых сложных коммуникативных ситуаций — ситуации сообщения плохих новостей. На материале реальных записей речи врачей проведен анализ рискогенных коммуникативных шагов в общении врача и пациента, определены максимально эффективные способы реализации речевых тактик врача в ситуации сообщения плохих новостей. Сделано заключение о необходимости повышения уровня профессиональной коммуникации врачей и обучения студентов медицинских вузов коммуникативным навыкам сообщения плохих новостей.

Ключевые слова: *речевая тактика, сообщение плохих новостей, врач, пациент, коммуникативные навыки*

Конфликт интересов

Авторы заявляют, что данная работа, её тема, предмет и содержание не затрагивают конкурирующих интересов

Источники финансирования

Авторы заявляют об отсутствии финансирования при проведении исследования

Статья получена 24.03.2021 г.
Принята к публикации 11.11.2021 г.

Для цитирования: Маркова А.А., Барсукова М.И. ТАКТИКА СООБЩЕНИЯ ПЛОХИХ НОВОСТЕЙ В ПРОФЕССИОНАЛЬНОМ ОБЩЕНИИ ВРАЧА И ПАЦИЕНТА. Архивъ внутренней медицины. 2021; 11(6): 136=142. DOI: 10.20514/2226-6704-2021-12-2-136-142

Abstract

The article is devoted to the development of the level of communicative competence of future doctors and the peculiarities of professional communication with patients. The basis of the work were the questions of determining the speech behavior of a doctor in one of the most difficult communicative situations — the situation of delivering bad news. Based on the material of real recordings of doctors' speech, the analysis of risky

*Контакты: Анна Александровна Маркова, e-mail: markova-ann@yandex.ru
*Contacts: Anna A. Markova, e-mail: markova-ann@yandex.ru
ORCID ID: https://orcid.org/0000-0001-8561-2214

communicative steps in the communication between the doctor and the patient is carried out, the most effective ways of implementing the doctor's speech tactics in the situation of bad news are determined. Conclusions are drawn about the need to improve the level of professional communication of doctors and to train medical students in the communication skills of delivering bad news.

Key words: *speech tactics, delivering bad news, doctor, patient, communication skills*

Conflict of interests

The authors declare no conflict of interests

Sources of funding

The authors declare no funding for this study

Article received on 24.03.2021

Accepted for publication on 11.11.2021

For citation: Markova A.A., Barsukova M.I. Tactics of Reporting Bad News in Professional Communication Between a Doctor and a Patient. The Russian Archives of Internal Medicine. 2021; 11(6): 136-142. DOI: 10.20514/2226-6704-2021-12-2-136-142

Introduction

Professional communication between a physician and a patient is the most important part of practical medicine. Physicians themselves, their patients and many researchers in this sector recognize the need and importance of the communicative aspect [1, 2]. As the adage goes: "The old doctor speaks Latin, the new doctor speaks English, the good doctor speaks the patient's language." Proper communication between a physician and a patient undoubtedly determines the patient's attitude towards the physician, the success of diagnosis and the management of the disease. The speech behavior of a physician and his/her communication skills help to find a common language with the patient.

Implementation of a new educational standard allowed the inclusion of the "Professional communication" course in the list of modules that are taught at the Department of Pedagogy, Educational Technologies and Professional Communication at V.I. Razumovsky Saratov State Medical University. The theoretical basis of professional communication and speech-behavioral models of various situations of medical discourse are honed in practical classes. Teaching staff performs a number of tasks: improve the general and communicative culture of future professionals; teach the basic tools of effective professional communication; develop the skills of conflict-free professional communication between a physician and a patient; study with students the practical methods of convincing patients and overcoming communication barriers that arise between a physician and a patient.

One of the most difficult issues to manage is the special situation in the interaction between the patient and the physician — delivering bad news to the patient. Insufficient exploration of this issue in domestic and foreign literature makes it relevant to study the communicative behavior of a physician when communicating with a patient in difficult life circumstances and presents a particular challenge in regard to the collection of information. In domestic medical, pedagogical, and psychological literature, this issue is usually addressed from the point of view of ethics and deontology [3–6]. Foreign studies describe several communication models tested in clinical practice [7, 8]. However, we should mention that many researchers only write that a physician should be more attentive, more tactful, etc., that is, he/she should comply with ethical standards. However, the analysis of specific speech and behavioral steps and the ways of their verbal and non-verbal expression are still not analyzed. Therefore, a physician can only guess what modes of communication will be appropriate and most effective and act according to his/her language habits.

According to the current legislation, a physician is obliged to provide a patient with complete information about the patient's disease [9]. Therefore, mastering the tactics of delivering bad news in different situations of institutional communication with patients becomes a mandatory professional skill for a physician.

A physician in his/her daily activities constantly has to face negative emotions of patients. The physician experiences enormous psychological stress when he/she has to deliver bad news to a patient.

In foreign literature, the term "bad news" means any information from a physician about the state of health that negatively and significantly changes the patient's idea of his/her future [10–12].

In Russian literature, bad news is divided into two types that seem relevant: actual bad news and unpleasant news [13]. *Bad news* is the news a physician has to deliver to patients, their partners and family members regarding a terminal illness, incurable disease, mutilation, sudden or predictable death. Bad news may include informing about serious illnesses with reversible processes (for example, syphilis, tuberculosis, etc.); fatal diseases with irreversible processes (for example, HIV, AIDS, leukemia, multiple sclerosis, metastatic malignant tumors, etc.); incurable diseases with severe or irreversible consequences (for example, diabetes mellitus, Down syndrome, hemophilia, schizophrenia, epilepsy, etc.); the patient's disability (for example, loss of limbs); informing relatives about the death of the patient, as a fait accompli. *Unpleasant news* means news that can make a patient experience such emotional reactions as fear, anxiety, worrying, sadness, grief. This may be informing a patient about upcoming surgery; a chronic disease (for example,

bronchitis, arterial hypertension, etc.); a limb fracture that causes an unpleasant experience in a patient (anxiety, fear, grief, etc.) [13].

The **SPIKES** model is the most developed and practically tested model for delivering bad news. This model includes six consecutive steps: **S** (setting) — preparing for a conversation, developing a plan for a conversation, creating a comfortable environment, allocating time for a conversation, ensuring confidentiality, determining the number of participants in a conversation. **P** (perception) — finding out what the patient already knows about his/her condition or disease, determining patient's expectations, his/her ideas about the current condition. **I** (invitation) — defining the information that the patient wants to hear; what is important for the patient to hear first of all; whether the patient wants to know all the details of the current situation. **K** (knowledge) — informing about the current condition and verbalization of the diagnosis: start with the fact that you have information about the current condition of the patient; do not underestimate, do not rush; provide information gradually; make sure the patient understands you; give support, express regret. **E** (emotion) — psychological support: provide time for the patient's emotional response; ask him/her how he/she feels; explain that his/her feelings are normal in this situation. **S** (strategy and summary) — development of a joint plan for further actions: discuss who can help and support the patient from his/her inner circle, from social organizations; warn the patient about possible unpredictable circumstances; let him/her know on what day and at what time he/she can contact you [7].

However, due to the lack of time, the conditions for creating a comfortable environment while talking with the patient, and other factors, it is hard to adhere to the above model in actual clinical practice. In light of this, it seems to us especially important and relevant to use verbal and non-verbal tactics when delivering bad news to a patient.

Objective of the study: to find the most effective ways to implement the tactics of delivering bad news.

Research problems: Analysis of challenging aspects in communication between a physician and a patient; analysis of the culture of delivering bad news in the practice of a physician, and describing communication errors in the speech behavior of a physician when implementing the tactics of delivering bad news using the example of real cases from the practice of a general practitioner.

Materials and Methods

This work is a single-center, cross-sectional study. This study was conducted in accordance with international and Russian ethical standards, the provisions of the Declaration of Helsinki, and was approved by the local Ethics Committee of V.I. Razumovsky Saratov State Medical University of the Ministry of Health of Russia. All patients and physicians signed informed consent for voluntary participation in the study. Inclusion criteria: presence of bad news that should be delivered to a patient, age 18+, signed informed consent.

Six female physicians took part in the conversation with patients; their work experience ranged from 3 to 10 years; they were general practitioners with an average age of 29 ± 4.3 years. The study involved 30 patients (20 females and 10 males, average age 54.3 ± 12.5 years).

Dialogs between a physician and a patient when delivering bad news to the patient were recorded and analyzed; they were collected via the participant observation method in the therapeutic departments of clinics in Saratov. Reasons for delivering bad news: newly diagnosed benign tumors and malignant tumors of internal organs. During the conversation, attention was paid to the physician's use of non-verbal ways of communicating with a patient. After recording the dialog, the attending physician clarified the details and features of the patient's clinical situation required for the full description of each specific case.

Results

In this article, to illustrate the issue under consideration, four clinical cases were selected, which demonstrate both the wrong speech behavior of a physician and the right choice of speech tactics and their verbal and non-verbal implementation.

Clinical Case No. 1

Let's consider a dialog between a physician and a patient.

Physician: *Ultrasound examination of abdominal organs revealed a mass in your liver.*

Patient (female): *What could it be? Is it serious?*

Physician: *We have to perform magnetic resonance imaging of the liver.*

Patient (female): *Could it be cancer?* (her expression changes.)

Physician: *Everything is possible.*

Was the behavior of the physician correct during this conversation? The patient definitely did not expect to receive such news. She was upset, began to worry about the news. Patients often lose appetite and stop sleeping, constantly thinking about their new problems; they worry and try to imagine possible outcomes. In this case, the etiology of the mass in the liver was not clear. It could be a liver cyst, hemangioma, nodular hyperplasia, adenoma. These lesions are benign and usually require follow-up. Could the patient be told that it could be cancer when the diagnosis is not confirmed? Of course, this news turned out to be "bad" for the patient because it

caused negative emotions and feelings. Every person might associate the very word "cancer" with an unfavorable prognosis. In our opinion, in this situation, the physician should have said that at present, we cannot say exactly what kind of mass it is. Further tests are required. The physician might have even reassured the patient that masses in the liver are more often benign, and examination methods sometimes can give inaccurate results (for example, magnetic resonance imaging of the liver could show no mass in the liver).

Clinical Case No. 2

Here is another example of how a physician should not talk to a patient. Patient I., male, 20. Examination revealed a malignant tumor of the colon, peritoneal carcinomatosis. Chemotherapy and extensive surgery are indicated. The patient inquired about his condition while the physician was doing her rounds. The physician replied that she would first speak with the patient's parents. After the physician left, the patient looked nervous. In the evening, the physician spoke to the patient's father, explained that the prognosis was unfavorable, and chemotherapy and several serious surgeries were required. What did the physician expect by talking first with the father but not with the patient himself? Apparently, deeply sympathizing with the patient, the physician tried to avoid an unpleasant conversation and tried to shift the responsibility for communicating the patient's diagnosis to the shoulders of his parents. Does a physician have the right to do such things? In accordance with current legislation — no. The patient is an adult. He wanted to know about his condition; he was worried and, of course, immediately understood that the physician was hiding something from him. And what about the patient's grief-stricken father, how well could he talk to his son? Will he be able to support his son in such a difficult time? When the patient sees his parents in distress, he would likely think that everything is very bad and could lose faith and hope for the future. In such a situation, the physician himself/herself should tell the patient about the diagnosis, methods of treatment, further prognosis, without hiding the truth from the patient. However, at the same time, the physician should give the patient some reassurance, making it clear that treatment exists and every effort should be made to combat the disease.

Delivering news to patients is a very difficult problem. After hearing a diagnosis with a poor prognosis from a physician, patients almost always ask: "How long do I have?" Despite that present-day medicine can determine the approximate life expectancy of patients with a particular pathology, no one, even the most experienced professional, can say how long the patient will live. This issue is undoubtedly very important for patients with severe diseases. After all, they try to imagine how to "build" their lives going forward, what to do with the time left. And if you say they have very little time? Unfortunately, many patients, in this case, lose hope, interest in life and die even faster than expected.

Clinical Case No. 3

Let's consider the behavior of a physician when communicating with a patient under follow-up for a long time for a malignant tumor of the pancreas with a poor prognosis. Patient, male, 51, was diagnosed with pancreatic adenocarcinoma. At the case conference, the tumor was regarded as unresectable. Median survival of such patients is six months [14]. During the first conversation, the physician clearly explained to the patient that life expectancy differs in different individuals with the same pathology and depends on many factors; she set the patient up to fight the disease. The patient was observed in the department for three years; the diagnosis was repeatedly confirmed; the patient was in constant contact with the attending physician, followed all the recommendations in a timely manner and felt good. This example demonstrates the longer life expectancy of a patient with cancer with a statistically low life expectancy; there was a trusting relationship between physician and patient and high adherence to therapy.

Clinical Case No. 4

This clinical case demonstrates correctly chosen tactics of speech behavior and the specific features of its implementation. Patient, male, 76. Examination revealed primary multiple malignant tumors of the colon and the stomach with severe concomitant pathology. On the case conference, tumors were regarded as unresectable. When speaking with the patient, the physician described the diagnosed pathology as follows:

Physician: Hello, I.M. (addresses by name and patronymic; takes a chair, sits next to the patient's bed). I.M., I have some not very good news to tell you (pauses). Based on the results of the examination, you have two tumors: in the stomach and the large intestines…unfortunately, you cannot be operated on…

Patient: So, life is over (doesn't look at the physician, stares ahead).

Physician: I.M., you know (puts his hand on the patient's forearm), the histological variant of tumors is not the worst. There are no metastases. I will tell you later what to do, what to eat, what drugs to take to treat anemia ... we will definitely deal with it and we will do our best to make you feel good...

The physician found the right words to encourage the patient, to inspire him with belief in the possibility of continuing to fight. At the level of speech implementation, the physician used the tactics of consolation, empathy and support, as well as the tactics of creating the line of thinking and explaining. Analysis of this material showed that the specific effective features included means

of harmonizing communication: "we" — which emphasized that the problem was shared (we will definitely deal with it and do our best); euphemisms demonstrating softening of categoricalness (not very good news). It should be noted that the patient's relatives played an important role in supporting him: they were very attentive, helped him feel needed and filled the patient's life with positive emotions and care; were constantly in contact with the attending physician and followed all the recommendations for treatment and care.

Discussion

The art of communication between a physician and a patient is a very complex and multifaceted process where a physician acts not only as a professional who uses his knowledge and experience for the treatment, rehabilitation and maintenance of the patient's health, but also as a person who analyzes the patient's treatment process in the context of moral, ethical, cultural, religious values. The art of communicating with a patient requires not only the desire of the physician but also the relevant knowledge. Future and practicing physicians usually master the skills of communicating with the patient based on their linguistic abilities during practice, adopting "a manner of speaking from clinicians or intuitively finding their own style, the success of which, however, may be in doubt" [2].

Physicians must be well versed in the principles of ethics and deontology in medicine, and have knowledge of communication psychology. Without sufficient knowledge in these areas, it is impossible to find the right individual approach to each patient.

The communicative culture of delivering bad news takes up a special niche in the physician's work. Despite that delivering bad news to a patient or his/her relatives is an integral part of the work of a practicing physician, it always causes tension in the emotional-volitional sphere. There is no doubt that the more severe and unfavorable a patient's prognosis, the more difficult it is for a physician to choose the right words and properly describe the problem. Not only young but also experienced professionals, deep down inside, do not want to deal with the negative emotions of patients. Such reluctance can lead to a situation where a physician either does not fully inform the patient about the diagnosis, trying to avoid unnecessary questions, or conveys it with detachment, hastily, not caring about the patient's mental state. Both scenarios of speech behavior, in this case, are risky and cannot be considered acceptable by a physician [15]. Of course, not only the patient experiences negative emotions while talking about the worsening of health. The physician also experiences anxiety and fear for the future of his/her patient. The physician understands that after this conversation, the patient's life will change and will never be the same.

A sick individual is very different from a healthy person in many ways: special physical condition during the period of illness, intensity of emotions, mental stress, belief in recovery, hope of returning to the family, labor

Table. *Verbal and nonverbal tactics when telling a patient bad news*

Verbal tactics
Consolation: "don't worry"; "we'll manage, we'll ease Your suffering"; "it could be worse"; "now you need to think about how to cope with the disease"
Support: "do not worry ahead of time, let's wait for the results of the study"; "You did the right thing, seeing the doctor just in time"; "first of all, You need to calm down"; "do not be afraid of this operation"; "don't worry, everything will go well"; "we are going to manage it, You are not alone, don't worry"
EEmpathy: "I know what you are going through"; "be patient a little, I understand that it hurts you, it will become much easier against the background of treatment"; "I understand that it is unpleasant to do this study, but it is necessary"
Nonverbal tactics
Touching, patting (takesika): touching the patient's forearm; shaking the hand; patting the shoulder to support the patient
Eye contact: making eye contact at the same eye level; do not turn away and do not avert your eyes during a conversation
Eye expression: kind, open, confident, warm, caring, soothing look
Facial expression (facial expressions): friendly, sympathetic, compassionate, but at the same time, encouraging and supportive facial expression
Pose (pantomime): straight back, slight tilt of the head or upper body towards the patient
Distance (distance to the interlocutor): the distance to the patient is about half a meter, sufficient for a confidential conversation; there are no barriers between the doctor and the patient (for example, a table)
Voice (intonation, volume, tone, rhythm): confidential intonation; soft speech, unhurried rhythm, semantic pauses in combination with visual contact

and social activity create a special atmosphere in relations between a physician and a patient. For many people, disease is a severe trauma that leads to noticeable mental changes: in the patient's attitude towards himself/herself, close ones, work, life. These psychoemotional changes in a person are due to physical suffering, disruption of their daily habits, the threat of various complications, dependence on others, worries and fear for the future [16].

Undoubtedly, how bad the news will be for the patient depends on his/her expectations, awareness of the illness, and how "sick" the person felt before receiving news about his/her state of health.

Knowledge of the laws of professional communication and ways to implement the tactics of delivering bad news will help physicians navigate a difficult situation, build the right communication strategy, support, and comfort the patient and significantly ease his/her negative response.

The table includes the most successful, in our opinion, verbal and non-verbal tactics that help physicians best deliver bad news to patients [17].

Conclusion

Knowledge of the laws of professional communication and the ability to choose the best speech tactics and ways of their verbal and non-verbal implementation are becoming critical in professional interaction between a physician and a patient when implementing the tactics of delivering bad news. Speech tactics required for delivering bad news include consolation, empathy, and support. It is recommended to include the "Professional Communication" course in the list of taught disciplines for students of medical institutions of higher professional education, for the specialty programs "General Medicine" and "Pediatrics". In practical classes, teaching staff should work out the basics of professional communication with students, pay special attention to the speech behavior of physicians in a difficult situation of interacting with a patient — delivering bad news. A graduate skilled in communicative behavior in various professional communication situations will fit the image of a physician, defined as the only possible in one of V.M. Bekhterev's principles: "If the patient does not feel better after talking with the physician, then this is not a physician".

Вклад авторов:

Все авторы внесли существенный вклад в подготовку работы, прочли и одобрили финальную версию статьи перед публикацией

Маркова А.А. (ORSID ID: https://orcid.org/0000-0001-8561-2214): концепция и дизайн исследования, получение данных, анализ и интерпретация данных, написание статьи, утверждение итогового варианта текста рукописи

Барсукова М.И. (ORCID ID: https://orcid.org/0000-0001-5277-8090): концепция и дизайн исследования, получение данных, анализ и интерпретация данных, написание статьи, утверждение итогового варианта текста рукописи

Author Contribution:

All the authors contributed significantly to the study and the article, read and approved the final version of the article before publication

Markova A.A. (ORCID ID: https://orcid.org/0000-0001-8561-2214): research concept and design, obtaining data, analyzing and interpreting data, writing articles, approving the final version of the publication

Barsukova M.I. (ORCID ID: https://orcid.org/0000-0001-5277-8090): research concept and design, obtaining data, analyzing and interpreting data, writing articles, approving the final version of the publication

Список литературы/References:

1. Клоктунова Н.А., Барсукова М.И., Рамазанова А.Я. и др. Набор речеповеденческих тактик врача-педиатра (на материале диагностической стратегии). Высшее образование сегодня. 2020; 4: 42-47. doi: 10.25586/RNU.HET.20.04.P.42
   Kloktunova N.A., Barsukova M.I., Ramazanova A.YA. et al. A set of speech-behavioral tactics of a pediatrician (based on the diagnostic strategy). Higher Education Today. 2020; 4: 42-47. doi: 10.25586/RNU.HET.20.04.P.42 [In Russian].
2. Барсукова М.И., Клоктунова Н.А., Романовская А.В. и др. Коммуникативная подготовка будущих врачей (на материале речевого поведения врачей акушеров-гинекологов). Мир науки, культуры, образования. 2020; 4 (83): 113-114. doi: 10.24411/1991-5497-2020-00695
   Barsukova M.I., Kloktunova N.A., Romanovskaya A.V. et al. Communicative training of future doctors (based on the material of speech behavior of obstetricians and gynecologists). The world of science, culture and education. 2020; 4 (83): 113-114 [In Russian].
3. Barsukova M.I., Rodionova T.V. Communicative risks in the dyad `doctor — patient`. Izvestiya of Saratov University. New Series. Series: Philology. Journalism. 2021; 21 (2): 176-179. doi: 10.18500/1817-7115-2021-21-2-176-179
4. Денисов И., Резе А., Волнухин А. Коммуникативные навыки. Сообщение плохих новостей. Врач. 2010; 12: 79-80.
   Denisov I., Reze A., Volnuhin A. Communication skills. Delivering of bad news. Vrach. 2010; 12: 79-80 [In Russian].
5. Саперов В.Н. Медицинская этика. М.: Бином. 2019; 232 с.
   Saperov V.N. Medical ethics. M.: Binom. 2019; 232 p [In Russian].
6. Шакарашвили М.В. Коммуникативный диалог врача и пациента. GESJ: Education Science and Psychology. 2012; 2(21): 79-80.
   Shakarashvili M.V. A communicative dialogue between a doctor and a patient. GESJ: Education Science and Psychology. 2012; 2(21): 79-80 [In Russian].
7. Bailea F.W., Buckmanb R., Lenzia R et al. SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. Oncologist. 2000; 5(4):302-311. doi:10.1634/theoncologist.5-4-302
8. Сильверман Дж., Керц С., Дрейпер Дж. Навыки общения с пациентами. Изд.: Гранат, 2018; 304 с.
   Sil'verman Dzh., Kerc S., Drejper Dzh. Skills for communicating with patients. Izd.: Granat, 2018; 304 p [In Russian].
9. Федеральный закон от 21.11.2011 N 323-ФЗ (ред. от 22.12.2020) «Об основах охраны здоровья граждан в Российской Федерации» (с изм. и доп., вступ. в силу с 01.01.2021). Правовой сервер «КонсультантПлюс» [Электронный ресурс]. URL: http://www.consultant.ru/document/cons_doc_LAW_121895/ (дата обращения: 26.01.2021).

Federal'nyj zakon ot 21.11.2011 N 323-FZ (red. ot 22.12.2020) "Ob osnovah ohrany zdorov'ya grazhdan v Rossijskoj Federacii" (s izm. i dop., vstup. v silu s 01.01.2021). Pravovoj server «Konsul'tantPlyus» [Electronic resource]. URL: http://www.consultant.ru/document/cons_doc_LAW_121895/ (date of the application: 26.01.2021) [In Russian].

10. Buckman R. Breaking bad news: the S-P-I-K-E-S strategy. Community Oncology. 2005; 2(2):183-142. doi:10.1016/S1548-5315(11)70867-1
11. Alshami A., Douedi S., Avila-Ariyoshi A. et al. Breaking bad news, a pertinent yet still an overlooked skill: an international survey study. Healthcare (Basel). 2020; 8(4):501. doi: 10.3390/healthcare8040501
12. Monden K.R., Gentry L., Cox T.R. Delivering bad news to patients. Proc (Bayl Univ Med Cent). 2016; 29(1): 1–2. doi:10.1080/08998280.2016.11929380
13. Казаева А.В., Носкова М.В. Культура сообщения плохих новостей в практическом здравоохранении: концепция формирования. Личность в меняющемся мире: здоровье, адаптация, развитие. 2016; 4(15): 66-71. doi: 10.23888/humJ2016466-71
Kazaeva A.V., Noskova M.V. The culture of delivering bad news in practical health care: a concept of formation. Personality in a changing world: health, adaptation, development. 2016; 4(15): 66-71. doi: 10.23888/humJ2016466-71[In Russian].
14. Ercan G., Karlitepe A., Ozpolat B. Pancreatic cancer stem cells and therapeutic approaches. Anticancer Research. 2017; 37 (6): 2761-2775. doi: 10.21873/anticanres.11628
15. Барсукова М.И., Шешнева И.В., Рамазанова А.Я. Рискогенность общения врача и пациента: коммуникативный аспект. Мир науки, культуры, образования. 2019; 3(76): 486-487.
Barsukova M.I., Sheshneva I.V., Ramazanova A.Ya. Risks of doctor-patient communication: a communicative aspect. The world of science, culture and education. 2019; 3(76): 486-487 [In Russian].
16. Гнездилов А.В. Психология и психотерапия потерь. СПб.: Речь. 2007; 162 с.
Gnezdilov A.V. Psychology and psychotherapy of losses. SPb.: Rech'. 2007; 162 p [In Russian].
17. Болучевская В.В, Павлюкова А.И. Общение врача: вербальная и невербальная коммуникация. (Лекция 2). Медицинская психология в России. 2007; 2(7).
Boluchevskaya V.V, Pavlyukova A.I. Doctor's communication: verbal and nonverbal communication. (Lecture 2). Med. psihol. Ross. 2007; 2(7) [In Russian].