

**BREAKING BAD NEWS IN EMERGENCY AND URGENT CARE SETTINGS: THE SPIKES
PROTOCOL AND THE STRATEGIC, YET UNDERVALUED, ROLE OF THE
MULTIDISCIPLINARY TEAM IN HUMANIZED CARE**

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**Filipi de Oliveira Souza¹, Hugo Rocha Frias Rabello², Mayla Elias da Silva³, Cristiane dos Santos
Lopes⁴, Breno Martins de Souza⁵, Mathias Pains Valim⁶, Alexandre Henriques Mattos da Cruz⁷,
Enoghalliton de Abreu Arruda⁸ and Larissa Pereira Costa⁹**

Abstract

Breaking bad news constitutes one of the most complex and emotionally demanding challenges in healthcare practice, particularly within emergency and urgent care settings, where the immediacy of decisions and the unpredictability of clinical outcomes intensify the vulnerability of patients, families, and healthcare professionals. This article aims to analyze, in light of contemporary scientific literature, the role of the SPIKES protocol as a structuring tool for breaking bad news, highlighting the performance of the multidisciplinary team as an indispensable component of this process, despite its historical undervaluation within decision-making spaces and institutional health policies. This is a qualitative narrative literature review based on publications indexed in national and international databases, covering the period from 2018 to 2025, aiming to update and expand previous discussions on the subject. The results indicate that the SPIKES protocol, structured in six sequential and adaptable stages, proves effective in organizing dialogue between professionals and patients, favoring the reduction of

¹ Undergraduate Nursing Student – Centro Universitário UniFAMESC

² Undergraduate Nursing Student – Centro Universitário UniFAMESC

³ Undergraduate Nursing Student – Centro Universitário UniFAMESC

⁴ Undergraduate Nursing Student – Centro Universitário UniFAMESC

⁵ Undergraduate Nursing Student – Centro Universitário UniFAMESC

⁶ Undergraduate Nursing Student – Centro Universitário UniFAMESC

⁷ Undergraduate Nursing Student – Centro Universitário UniFAMESC

⁸ PhD in Education from the Universidade Católica de Petrópolis (UCP)

Professor at Centro Universitário UniFAMESC

E-mail: enoghalliton.arruda@hotmail.com

ORCID: <https://orcid.org/0000-0001-5634-4724>

⁹ PhD in Nursing (UFRJ)

Professor at Centro Universitário UniFAMESC

E-mail: larissapcosta90@gmail.com

ORCID: <https://orcid.org/0000-0003-1275-1349>

psychological distress, strengthening of the therapeutic bond, and shared decision-making. It was also found that effective communication of bad news should not be the exclusive responsibility of physicians but a shared responsibility of the entire multidisciplinary team – nurses, psychologists, social workers, physical therapists, pharmacists, and other professional groups – whose integrated performance is frequently rendered invisible within institutional protocols and traditional academic training. It is concluded that the systematic incorporation of the SPIKES protocol, associated with the recognition and appreciation of multidisciplinary work, represents a promising path toward the humanization of care in urgent and emergency care settings, requiring investments in continuing education, curricular revision, and institutional policies of professional recognition.

Keywords: Emergency Care, Health Communication, Humanization of Care, Multidisciplinary Team, SPIKES Protocol.

INTRODUCTION

Communication is a foundational element of human relationships and assumes an even more critical dimension in healthcare, as it mediates relationships among professionals, patients, and families during moments of profound emotional and existential vulnerability. Among the many competencies required of healthcare professionals, the ability to break bad news stands out as one of the most challenging because it involves conveying information that drastically and often irreversibly alters patients' perspectives on their own future (Fallowfield; Jenkins, 2004; Baile et al., 2000).

According to the specialized literature, bad news refers to any information that substantially and negatively changes an individual's perception of themselves, their health, or their prognosis (Buckman, 1992). In urgent and emergency care settings, this reality is intensified by the unpredictability of events, the limited time available to prepare those involved emotionally, heavy workloads, and the need for rapid and assertive decision-making.

In these settings, inadequate communication can have significant consequences, such as increased psychological distress among patients and families, erosion of trust in the healthcare team, impaired treatment adherence, and even ethical and legal implications for the institution and the professionals involved (Silva; Pereira, 2021).

Historically, academic education in the health professions has prioritized the development of technical and procedural competencies, relegating communication and relational skills to a secondary position. These skills have sometimes been regarded as innate gifts rather than competencies that can be systematically taught and improved (Ramos; Almeida, 2020).

This landscape began to change with the dissemination of structured communication protocols, among which the SPIKES protocol, originally developed by Baile et al. (2000) in the context of oncology, stands out as an internationally recognized framework. Comprising six sequential steps, namely Setting, Perception, Invitation, Knowledge, Emotions, and Strategy and Summary, the protocol provides a practical, replicable framework that can guide professionals through difficult conversations without constraining the sensitivity and uniqueness of each therapeutic encounter.

Although it originated in oncological communication, the SPIKES protocol has been widely adapted and used in multiple clinical contexts, including chronic degenerative diseases, infertility, sudden deaths, diagnoses of disability, treatment failure, and, more recently, hospital urgent and emergency care settings, in which time constraints and emotional intensity require specific methodological adaptations (Menezes et al., 2022; Costa; Rodrigues, 2023).

This specific focus underpins the academic and social relevance of the present study: investigating how the SPIKES protocol can be used in highly complex care settings characterized by urgent decision-making, and how the multidisciplinary team, which is frequently relegated to a supporting role in discussions of health communication, is in fact indispensable to the delivery of ethical, humanized, and effective care.

The decision to broaden the focus to include the multidisciplinary team is justified by the finding, extensively documented in the recent literature, that breaking bad news is not, and should not be, the exclusive prerogative of physicians (Oliveira; Santos, 2022).

Nurses, psychologists, social workers, physical therapists, occupational therapists, pharmacists, and other professionals routinely mediate sensitive information, provide emotional support to patients and families, and coordinate psychosocial support networks. Nevertheless, these professionals frequently face institutional invisibility, a lack of specific formal training, and symbolic and financial devaluation, which compromise the quality of care provided and contribute to emotional overload, professional burnout, and job dissatisfaction (Ferreira; Nascimento, 2023).

Against this backdrop, the general objective of the present study is to analyze, based on the current scientific literature, the role of the SPIKES protocol in breaking bad news in healthcare, with an emphasis on urgent and emergency care departments and other hospital settings, while highlighting the strategic yet paradoxically undervalued role of the multidisciplinary team in this process. The specific objectives were to: (i) describe the structure, theoretical foundations, and contemporary adaptations of the SPIKES protocol; (ii) discuss the communication challenges inherent in urgent and emergency care settings; (iii) highlight the multidisciplinary team's contribution to breaking bad news and the factors associated with its institutional devaluation; and (iv) propose approaches and strategies for addressing these weaknesses, with a view to humanizing care and strengthening continuing health education policies.

The social relevance of this investigation lies in the urgent need to improve the quality of care provided during moments of extreme human vulnerability, thereby helping to reduce avoidable suffering and strengthen trust in healthcare institutions.

From an academic perspective, the study contributes to a deeper theoretical understanding of health communication by bringing together bioethics, humanization, and professional appreciation, topics that remain insufficiently explored in an integrated manner in Brazilian literature, particularly regarding the intersection between structured communication protocols and recognition of teamwork.

METHODOLOGY

This is a qualitative, descriptive-exploratory narrative literature review whose purpose is to synthesize, interpret, and critically integrate the available scientific knowledge on the application of the SPIKES protocol to breaking bad news, with an emphasis on the role of the multidisciplinary team in urgent and emergency care departments and other hospital units. The methodological choice of a narrative review rather than a systematic review or meta-analysis is justified by the nature of the object of study, which requires a broad, interpretive, and reflective approach capable of integrating different theoretical perspectives, care settings, and ethical dimensions involved in the topic (Rother, 2007; Cordeiro et al., 2021).

The present study was conducted through the following methodological stages: (1) formulation of the guiding question; (2) definition of search and selection criteria; (3) bibliographic searches of scientific databases; (4) critical reading and selection of materials; (5) thematic organization of the content; and (6) analytical and interpretive reporting of the findings.

The guiding question for this review was formulated using the PICO strategy (Population, Interest, Context) and defined as follows: “What is the role of the SPIKES protocol and the multidisciplinary team in breaking bad news in urgent and emergency care departments and other hospital settings?”

The literature search was conducted in the following electronic databases: Latin American and Caribbean Health Sciences Literature (Literatura Latino-Americana e do Caribe em Ciências da Saúde, LILACS), Medical Literature Analysis and Retrieval System Online (MEDLINE), through the Virtual Health Library (Biblioteca Virtual em Saúde, BVS/BIREME), National Library of Medicine (PubMed), Scientific Electronic Library Online (SciELO), and Scopus. The following descriptors, indexed in the Health Sciences Descriptors (Descritores em Ciências da Saúde, DeCS) and Medical Subject Headings (MeSH), were used: “comunicação em saúde” / “health communication”; “comunicação de más notícias” / “breaking bad news”; “protocolo SPIKES” / “SPIKES protocol”; “equipe multiprofissional” /

“multidisciplinary team”; “urgência e emergência” / “emergency care”; and “humanização da assistência” / “humanization of care,” combined using the Boolean operators AND and OR.

The following inclusion criteria were established: (a) original articles, literature reviews, case studies, and experience reports published in indexed journals; (b) publications in Portuguese, English, or Spanish; (c) full-text availability; and (d) publications dating from 2018 to 2025, except for classic and foundational references on the SPIKES protocol and breaking bad news that were considered indispensable for the historical and conceptual contextualization of the topic, even if published before this period. The following were excluded: (a) editorials, letters to the editor, and conference proceeding abstracts for which the full text was unavailable; (b) duplicate studies found across the databases searched; (c) publications that, after full-text review, were not directly related to the study objectives; and (d) materials with no identifiable methodological rigor.

The selection process followed the flow recommended by literature review guidelines, resembling the PRISMA model adapted for narrative reviews, and comprised the identification, screening, eligibility, and inclusion stages. Initially, 312 records were identified in the databases searched. After duplicates were removed ($n = 58$), 254 studies remained and underwent title and abstract screening. At this stage, 168 records were excluded because they did not meet the established thematic criteria. The remaining 86 studies were read in full, resulting in the exclusion of 41 articles due to a lack of methodological rigor, inconsistency with the scope of the research, or the unavailability of the full text. At the end of the process, 45 studies were selected to constitute the analytical corpus of the present review. These were supplemented by the classic reference literature on the SPIKES protocol and by institutional and regulatory documents relevant to the topic, such as resolutions issued by professional councils and guidelines from the Ministry of Health.

Data analysis was conducted using the thematic content analysis technique proposed by Bardin (2016), encompassing the stages of pre-analysis, exploration of the material, and treatment of the results through inference and interpretation. Based on this technique, the following analytical categories were

developed to structure the present article: (i) theoretical foundations of health communication; (ii) structure and applicability of the SPIKES protocol; (iii) specific aspects of breaking bad news in urgent and emergency care settings; (iv) the role of the multidisciplinary team in this process; (v) institutional and symbolic devaluation of nonphysician professionals; and (vi) coping strategies and pathways toward improving the quality of care.

It should be noted that, because this study was based exclusively on publicly available secondary sources, submission to a Research Ethics Committee was not required, pursuant to Resolution No. 510/2016 of the National Health Council (Conselho Nacional de Saúde), which waives this requirement for studies using publicly accessible information without the direct involvement of human participants.

DEVELOPMENT

HEALTH COMMUNICATION: THEORETICAL FOUNDATIONS AND CONTEMPORARY CHALLENGES

Health communication extends beyond the mere transmission of technical information, constituting a complex relational process shaped by cognitive, emotional, cultural, and ethical dimensions (Araújo; Cardoso, 2021).

According to the biopsychosocial model, which has been widely adopted in contemporary health sciences, care cannot be limited to the biological dimension of disease. It must also incorporate patients' subjective perceptions, their sociocultural context, and their family and community support networks (Engel, 1977; Almeida; Ferreira, 2020). From this perspective, communication plays a central role as a therapeutic instrument capable of strengthening relationships, promoting treatment adherence, and mitigating the psychological distress associated with illness.

Recent studies have shown that the quality of communication between healthcare professionals and patients is directly associated with more favorable clinical outcomes, greater satisfaction with the care

received, fewer lawsuits alleging error or negligence, and lower levels of illness-related anxiety and depression (Travassos; Martins, 2022).

Conversely, poor communication, characterized by excessively technical language, a lack of active listening, disregard for patients' emotions, or the abrupt disclosure of sensitive information, has been associated with traumatic experiences, loss of trust in the care team, and worsening psychological distress (Barbosa; Lima, 2021).

Regarding the disclosure of bad news specifically, the literature describes this practice as one of the most delicate moments in the professional-patient relationship. It requires competencies that extend beyond technical and scientific knowledge, demanding sensitivity, empathy, listening skills, and proficiency in structured communication strategies (Buckman, 1992; Fallowfield; Jenkins, 2004). According to Kübler-Ross (1969), in her seminal work on the dying process, the manner in which information is communicated can largely determine how patients and their families process anticipatory grief or cope with a new health condition, reinforcing the ethical responsibility inherent in this communicative act.

Historically, the education of healthcare professionals has prioritized the development of technical and procedural competencies, relegating communication skills to a secondary position and often treating them as personality traits rather than competencies that can be systematically taught (Ramos; Almeida, 2020).

This conception began to be challenged in the 1990s, when research in medical education and health sciences began to demonstrate that communication, like any other clinical competency, can and should be taught, practiced, and assessed through active methodologies, realistic simulations, and structured protocols (Baile et al., 2000; Kurtz; Silverman; Draper, 2005).

In this context, several models for breaking bad news have been developed over the past three decades. These include the BREAKS protocol (Narayanan; Bista; Koshy, 2010), the ABCDE model (Rabow; McPhee, 1999), and, with the greatest international reach and applicability across multiple

contexts, the SPIKES protocol (Baile et al., 2000), which is the central subject of analysis in the present article. The decision to examine the SPIKES protocol in greater depth is justified by its extensive empirical validation, its flexibility for application across different specialties and professional groups, and its increasing incorporation into institutional guidelines and health professions curricula in Brazil and worldwide (Menezes et al., 2022).

THE SPIKES PROTOCOL: STRUCTURE, FOUNDATIONS, AND CONTEMPORARY ADAPTATIONS

The SPIKES protocol was originally proposed by Baile et al. (2000), researchers affiliated with the MD Anderson Cancer Center, to systematize the communication of unfavorable diagnoses and prognoses in oncology. The acronym SPIKES represents six sequential steps conceived not as a rigid script, but as a flexible guide that can be adapted to the particular circumstances of each clinical encounter, as detailed below.

The first step, Setting, concerns the physical and relational conditions under which the news will be delivered. A private space that ensures confidentiality and minimizes interruptions is recommended, as are advance planning of the content to be communicated, review of the medical record, and determination of who should be present during the conversation (Baile et al., 2000; Costa; Rodrigues, 2023).

In urgent and emergency care settings, this step is one of the greatest operational challenges because of the limited availability of private spaces, bed overcrowding, and the need to care simultaneously for multiple critically ill patients (Menezes et al., 2022).

The second step, Perception, consists of determining, before conveying any information, what patients and/or their families already understand about the clinical situation. This step allows professionals to identify cognitive distortions, unrealistic expectations, or denial mechanisms and to tailor their language and subsequent approach to the specific needs of each person involved in the conversation (Baile et al., 2000; Silva; Pereira, 2021).

The third step, Invitation, concerns patients' right to determine the level of detail they wish to receive, with respect for their autonomy and their cultural, emotional, and cognitive circumstances. This principle directly reflects the bioethical foundations of autonomy and informed consent, recognizing patients as active participants rather than merely passive recipients of information (Beauchamp; Childress, 2013; Oliveira; Santos, 2022).

The fourth step, Knowledge, refers to the actual communication of information. It should be conducted using clear, accessible language free from excessive technical jargon, avoiding both excessive euphemism, which may generate false hope, and informational brutality, which may constitute symbolic violence (Buckman, 1992; Ferreira; Nascimento, 2023). The use of short sentences, strategic pauses, and continuous checks of the other person's understanding is recommended.

The fifth step, Emotions, is perhaps the most complex and frequently neglected in clinical practice. It involves recognizing, naming, and responding supportively to patients' and families' emotional reactions, including crying, silence, denial, anger, or despair, through active listening, emotional validation, and empathic presence (Baile et al., 2000; Barbosa; Lima, 2021). At this stage, the involvement of professionals specifically trained in mental health, such as psychologists, is particularly relevant. However, as discussed below, their participation is frequently deferred until after the initial disclosure rather than being integrated into the process from the outset.

Finally, the sixth step, Strategy and Summary, consists of jointly developing a subsequent care plan, clearly defining the next therapeutic steps, addressing any remaining questions, and reaffirming the team's commitment to continuity of care. This is essential to building trust and reducing the sense of abandonment frequently reported by patients and families after receiving bad news (Costa; Rodrigues, 2023).

Recent studies have proposed adaptations of the SPIKES protocol for specific contexts, such as communicating a death in emergency units (Menezes et al., 2022), communicating via telemedicine (Travassos; Martins, 2022), and pediatric communication (Almeida; Ferreira, 2020). These adaptations

demonstrate the methodological flexibility of the model and its capacity to address a wide range of care needs without losing its foundational structure.

SPECIFIC ASPECTS OF BREAKING BAD NEWS IN URGENT AND EMERGENCY CARE SETTINGS

Urgent and emergency care departments have characteristics that substantially distinguish them from other care settings and create specific challenges for applying structured communication protocols. These characteristics include the unpredictability of clinical events, which prevents patients and families from preparing in advance; severe time constraints, which require rapid decisions and communication, often without sufficient time to establish a prior relationship; high turnover among professionals and patients, which hinders continuity of care and the development of lasting relationships of trust; and teams' physical and emotional overload resulting from overcrowding, shortages of human and material resources, and continuous exposure to suffering and death (Silva; Pereira, 2021; Menezes et al., 2022).

In these contexts, bad news is frequently disclosed under adverse conditions, including busy corridors, improvised waiting areas, the presence of other patients and families, and constant interruptions caused by competing care demands. Such conditions directly undermine the first step of the SPIKES protocol, Setting, requiring professionals to exercise creativity and flexibility in adapting the available environment to minimum standards of privacy and compassionate support (Costa; Rodrigues, 2023).

Furthermore, the sudden and often fatal nature of the events treated in urgent and emergency care services, including multiple trauma, acute myocardial infarction, stroke, suicide attempts, and unexpected deaths, requires professionals to convey extremely serious news to family members who may not have had time to process the severity of the situation before being informed of the final outcome (Ferreira; Nascimento, 2023).

This reality intensifies the emotional burden both for those receiving the news and for the professionals responsible for communicating it, creating conditions conducive to moral distress and burnout syndrome among healthcare workers (Travassos; Martins, 2022).

Research indicates that the lack of specific formal training in breaking bad news in urgent and emergency care settings is one of the main gaps in the education of Brazilian healthcare professionals. This results in inconsistent communication practices, often based on individual intuition and accumulated practical experience rather than an established technical and scientific foundation (Oliveira; Santos, 2022). This situation reinforces the urgent need for institutional investment in continuing professional development, simulation-based training, and clinical supervision to improve team performance and mitigate the adverse effects of inadequate communication.

THE ROLE OF THE MULTIDISCIPLINARY TEAM IN BREAKING BAD NEWS

The contemporary literature has increasingly recognized that breaking bad news is not the exclusive responsibility of physicians, but rather a process shared and continuously developed by the entire interprofessional healthcare team (Oliveira; Santos, 2022; Ferreira; Nascimento, 2023). Although physicians often formally communicate the diagnosis or prognosis, preparing patients and families, providing subsequent emotional support, and offering ongoing assistance as they process the news are largely undertaken by other professionals. Nevertheless, these contributions frequently remain overlooked in institutional records and the traditional scientific literature.

Because of their consistent and extended contact with patients and families, nurses play a crucial role in the early identification of signs of psychological distress, the mediation of questions and concerns that were not expressed during the consultation with the physician, and the continuity of care following the initial disclosure (Barbosa; Lima, 2021). Studies indicate that nurses frequently serve as “translators” of medical information, restating in accessible language what may have been communicated in

excessively technical terms, in addition to providing ongoing emotional support that is often absent from the initial encounter (Araújo; Cardoso, 2021).

Psychologists, in turn, have specific training in managing intense emotional reactions and are therefore essential to the Emotions step of the SPIKES protocol, as well as to supporting anticipatory grief, mediating family conflicts resulting from the impact of the news, and safeguarding the mental health of professionals exposed to highly emotionally demanding situations (Ramos; Almeida, 2020). Nevertheless, research indicates that the presence of psychologists in Brazilian urgent and emergency care departments remains limited and is confined to a small number of referral services, which compromises the comprehensiveness of psychosocial care in these settings (Silva; Pereira, 2021).

Social workers play a strategic role in coordinating family and community support networks, providing guidance on social security and welfare rights resulting from new diagnoses or disabilities, and mediating socioeconomic conflicts that frequently emerge in situations involving serious illness or sudden death (Cordeiro et al., 2021).

Physical therapists and occupational therapists contribute to the communication of bad news concerning functional limitations and rehabilitation prognoses, which requires particular sensitivity when conveying information about permanent or partial functional loss (Almeida; Ferreira, 2020). Although they are less frequently associated with this topic in the literature, clinical pharmacists also participate in the process by clarifying treatment changes, the adverse effects of palliative therapies, and the limitations of pharmacological interventions in cases involving a poor prognosis (Travassos; Martins, 2022).

This interprofessional perspective is directly aligned with the concept of collaborative care, according to which the quality of healthcare is directly proportional to the degree of integration and communication among different team members (Peduzzi; Agreli, 2018). Nevertheless, the literature indicates that, in the day-to-day practice of Brazilian urgent and emergency care services, this integration remains more rhetorical than effective. It is frequently undermined by rigid professional hierarchies, the

fragmentation of healthcare work, and the absence of formal opportunities for interdisciplinary case discussions (Peduzzi; Agreli, 2018; Ferreira; Nascimento, 2023).

INSTITUTIONAL AND SYMBOLIC DEVALUATION OF THE MULTIDISCIPLINARY TEAM

Despite the demonstrated importance of interprofessional practice in breaking bad news, the literature reviewed reveals a recurring pattern of institutional, symbolic, and, in many cases, financial devaluation of these professional groups in comparison with the historical centrality assigned to physicians (Peduzzi; Agreli, 2018).

This devaluation manifests itself in several ways, including the absence of explicit references to other professional groups in institutional protocols for breaking bad news, which are frequently written with an exclusive focus on physicians' practice; the scarcity of formal training specifically aimed at nurses, psychologists, social workers, and other professionals regarding techniques for breaking bad news; the unacknowledged emotional burden borne by professionals who provide support following disclosure without formal recognition of this role; and weak institutional mechanisms for psychological support and clinical supervision intended to mitigate the emotional strain arising from this work (Ferreira; Nascimento, 2023).

This devaluation has historical roots in the hegemonic biomedical model, which for decades relegated other professional groups to a subsidiary and complementary role in relation to physicians, establishing a hierarchy that privileged technical and scientific knowledge over the relational and psychosocial dimensions of care (Peduzzi; Agreli, 2018).

This model, which remains dominant in many Brazilian healthcare institutions, runs counter to the principles established by the National Humanization Policy (Política Nacional de Humanização, PNH), instituted by the Ministry of Health in 2003. The policy advocates shared responsibility among all healthcare professionals for comprehensive patient care and the appreciation of teamwork as a foundational component of humanized care (Brasil, 2003; Brasil, 2013).

The consequences of this devaluation are not limited to the symbolic dimension. They directly affect the quality of care provided and the mental health of healthcare workers themselves. Studies indicate alarming levels of professional burnout, anxiety, and moral distress among nurses, psychologists, and social workers employed in urgent and emergency care departments. These outcomes are associated, among other factors, with the emotional burden arising from continuous exposure to situations involving the communication of bad news without adequate institutional support and professional recognition (Travassos; Martins, 2022; Ferreira; Nascimento, 2023).

This situation therefore creates a vicious cycle: overburdened and overlooked professionals tend to experience greater emotional exhaustion, which in turn impairs their ability to provide empathetic, high-quality care, perpetuating the suffering of patients, families, and the team itself.

PATHWAYS AND STRATEGIES FOR IMPROVING THE QUALITY OF CARE

Overcoming the weaknesses identified requires coordinated, multidimensional strategies involving changes in academic education, institutional policies, and the organizational culture of healthcare services. First, undergraduate health professions curricula must be revised to incorporate the systematic teaching of techniques for breaking bad news, including the SPIKES protocol and its variations, in a cross-cutting and interprofessional manner through active methodologies such as simulation-based training, role-playing, and reflective clinical supervision (Kurtz; Silverman; Draper, 2005; Ramos; Almeida, 2020).

Second, continuing health education programs should be implemented for all practicing professional groups, with emphasis on updating communication competencies and strengthening teamwork, in accordance with the guidelines of the National Policy for Continuing Health Education (Política Nacional de Educação Permanente em Saúde) (Brasil, 2004). These programs should encompass not only technical training but also supportive spaces and mental healthcare for professionals, recognizing the cumulative emotional impact of frequent exposure to suffering and death.

Third, institutional protocols for breaking bad news must be revised to formally and explicitly include all professional groups involved in the process, thereby moving beyond the historically established exclusive centrality of physicians. This revision should be undertaken collaboratively, with representatives of all professional groups, to ensure the legitimacy and practical applicability of the resulting guidelines (Peduzzi; Agreli, 2018).

Finally, permanent institutional forums should be established for interdisciplinary discussions of complex cases, including regular interprofessional meetings and humanization committees. These forums should foster the collective development of care strategies, shared responsibility, and mutual recognition among the different professional groups involved in breaking bad news (Brasil, 2013). In addition to improving the technical quality of care, these initiatives contribute significantly to creating healthier, more collaborative, and more humanized working environments for professionals, patients, and their families.

FINAL CONSIDERATIONS

This narrative review has demonstrated that breaking bad news, particularly in urgent and emergency care departments, is one of the most complex and emotionally demanding challenges in healthcare practice. It requires professionals to possess competencies that extend beyond technical and scientific expertise and encompass sensitivity, empathy, and skilled listening. The SPIKES protocol proved to be an effective framework for organizing this communication process, offering a flexible approach that can be adapted to the particular circumstances of each therapeutic encounter without constraining the uniqueness and humanity inherent in this highly sensitive moment within caregiving relationships.

The review also found that effectively breaking bad news cannot and should not be understood as the exclusive responsibility of physicians, but rather as a responsibility shared and continuously developed by the entire interprofessional healthcare team.

Nurses, psychologists, social workers, physical therapists, pharmacists, and other professional groups play an indispensable role in preparing for, conducting, and ensuring continuity throughout this process. They make a decisive contribution to reducing psychological distress among patients and families and strengthening the therapeutic relationship. Paradoxically, however, this contribution continues to be frequently overlooked in institutional protocols, traditional academic education, and professional recognition policies, perpetuating a hierarchical and fragmented model of care that runs counter to the fundamental principles of humanized healthcare.

Against this backdrop, it is concluded that the systematic incorporation of the SPIKES protocol, together with the formal recognition and institutional appreciation of interprofessional work, represents a promising and necessary path toward improving the communication of bad news and humanizing care in urgent and emergency settings. This transformation, however, requires consistent investment in continuing education, interprofessional curriculum revision, the reformulation of institutional protocols, and the strengthening of public policies aimed at valuing all professional groups involved in healthcare.

The limitations of the present study include its narrative review design. Although this design allows for a broad and interpretive approach to the object under investigation, it does not follow the standards of systematicity and reproducibility characteristic of systematic reviews, which may entail a certain degree of selectivity in choosing and interpreting the sources consulted.

It is therefore recommended that future studies further investigate the effectiveness of the SPIKES protocol in Brazilian urgent and emergency care settings through field research, intervention studies, and qualitative assessments of different professionals' perceptions of their roles in breaking bad news. Such research could contribute to a stronger theoretical and empirical foundation for this topic, which remains insufficiently explored in Brazilian literature.

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