Bad News or Really Bad News?

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"I'M AFRAID I have some bad news." I said in English and then paused to wait for a nurse to interpret my words into Chichewa despite myriad patients simultaneously needing her attention. Not knowing what I would say next, I looked around the hospital ward for someone to help me through this conversation. Instead, I saw beds full of critically ill children packed 5 to 6 per bed, open windows with no panes or screens, and sheets of paper taped to the walls marked "Pneumonia Bay" and "Malaria Bay." My patient's mother held her daughter's hand and tears welled up in her eyes while she questioned in Chichewa, "Bad news or really bad news?" I hesitated, looked at her daughter in the bed between us and replied in English, "Well, it's really bad news."

This encounter came just minutes after a young Malawian intern with bags under his eyes and a short-sleeved white coat with faded bloodstains had recounted the patient's history to me beside her rusty hospital bed. He wiped sweat from his forehead while I placed my fingers on the child's frail wrist, searching for a pulse. "This 3-year-old, previously healthy girl was involved in an auto–pedestrian accident last night. She stepped onto the highway and was hit by a small bus. She was found unresponsive at the scene and suffered a massive intracranial hemorrhage noted on head computed tomography. She was intubated upon arrival with a Glasgow Coma Scale score of 3." Listening, I watched the young girl's mother slowly squeeze and release a self-inflating airway bag attached to the end of the child's endotracheal tube. There were no ventilators available for this child at the national referral hospital in Lilongwe, Malawi where I would work for the next 12 months.

It was my first day. Jetlagged from the more than 30 hours of travel but eager to begin work in my new surroundings, I had been awake since 2:30 AM. Yet, my preparation for this day really began 2 years before this moment when I matched at Texas Children's Hospital in the Global Child Health residency program. It was through that program that I would spend an additional year of residency at one of the Baylor International Pediatric AIDS Initiative sites in sub-Saharan Africa. This decision was founded on hopes of saving lives, improving health care delivery, and launching a career in academic global health. Perhaps lofty aspirations.

Walking into the poorly lit corridor of the hospital that was lined with mothers and their children waiting to be attended to that morning, I had made a mental list of questions I would ask as part of my orientation that day. What labs and imaging would be available? Who would I call if I didn't know how to manage conditions that were common in Malawi but rare in the United States? What medications would be available? However, as I entered the large, open hospital ward and saw the scene in front of me, I knew my questions would have to wait.

I had a hard time finding the child's pulse while receiving sign-out on the patient from the wearied intern who was on call the night before. Her heart sounds were inaudible over the sound of the mother's hopeful and earnest bagging. The mother's exhausted eyes looked on as I examined her daughter. She had been squeezing that bag for hours to make up for the lack of a ventilator for her daughter. Her extremities had a profound coldness that I had never felt before. I asked the mother to stop filling her daughter's lungs with air so that I could assess the child's unassisted cardiorespiratory status. I auscultated throughout the small child's precordium: no heart sounds. I felt again for a pulse that was not there. There was no telling how long the child had been pulseless but her frigid extremities and the absence of heart sounds told me that it had been some time. My heart sank. I turned away from my patient to search for the intern who had admitted her, hoping that his rapport and language abilities would aid in the delivery of such devastating news to that mother. He was nowhere to be found.

Suddenly the realization that there was no attending for me to turn to and no fellow to page came crashing down on

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me. It was my responsibility alone to have this critical conversation. After pausing for a moment to imagine myself in this mother's position, I began to convey the news that the mother's eyes told me she already knew, "I'm terribly sorry. Despite all of our best efforts, your daughter has died." The wailing began once my words were interpreted into Chichewa. The mother's knees buckled, a family member sprang to support her limp body. The mother turned to her daughter lying in the hospital bed and then slowly leaned over to kiss her cheeks; kisses that were partially obstructed by the child's breathing tube. I stood at the bedside and watched, not knowing what to say or do. Minutes passed. Then the child's mother turned and walked out of the large, busy hospital ward and into the quiet, dusty hallway. For a brief moment, the echoes of this mother's mourning coalesced with those of other families in the hallway to flood the ward. It was the rainy season in Malawi when malaria, diarrheal illnesses, and malnutrition claim the lives of far too many children.

As soon as the mother stepped into the hallway, the well-rehearsed ritual of preparing the child's body to be transported to the morgue began. One nurse covered the child's face with a gray sheet. Another removed the intravenous line from the child's arm and another brought a gurney with a squeaky wheel to transport the child. No words were spoken. There was no need for words. Each of those nurses had each done this more times than they would care to admit or remember. Finally, one nurse turned to me and said, "Doctors pull the tube." Still in shock from what I had just witnessed and how unprepared I felt to handle such shattering events, I carefully peeled back the tape, let down the cuff, and removed the child's breathing tube.

I had been charged with delivering this news to this parent just minutes after first seeing her daughter. I lacked rapport with the parent and my new team. The nurse who offered to help me was not a trained interpreter and interpreting was not part of her job description. My excitement to be in the role of an attending for the first time was squashed.

Whether there are ventilators or not, whether there is air conditioning or not, and whether there are panes on the windows or not, the delivery of critical news is an immense challenge. The adage of 'see one, do one, teach one' echoes through the halls of teaching institutions throughout the United States. Although I had not yet seen such sad information delivered in my home country, that responsibility had become mine thousands of miles away in Malawi. I had previously thought there was something about the transition from trainee to attending that confers the ability to gracefully deliver such news. I felt no such bestowing of a new skill in that moment.

As my first day went on, I witnessed several limp children carried into the wards wrapped in colorful cloth and strapped to their mothers' backs. I realized that many parents in Malawi viewed hospitals as a place where children go to die and I was at the edge of the precipice, the last provider, and even the last gateway to stave off death.

After my patient was wheeled out of the ward and before I fully absorbed what had happened, I heard, "Dr. Chris, can you help us with another patient?" I turned to see an intern across the room starting chest compressions on a child and rushed across the ward to help.

After my new patient was stabilized, I walked through the meandering halls that led to the morgue to look for the mother of my first patient. She was not there. I did my best to describe her to the staff at the desk but my queries were met with shaking heads. Feeling incomplete and undone but knowing there were many patients to be seen, I returned to the ward. As the day went on, I returned to the morgue several times to look for my patient's mother, but my search was in vain.

Looking back on this experience now, I realize that I did not know what words I would have used if I had found her. Would I have said, "I can only imagine how you feel" or "I'm so sorry for your loss"? These words seem inadequate, but for my own well-being I had wanted to connect with the mother in solidarity by simply being with her, on a seemingly deeper level than just the provision of finite medical actions.

I discovered that I would have to deliver "really bad news" many times in Malawi. And I now recognize that there will be moments like this throughout my career as I continue to work in the United States and well beyond its borders—the first discussion about brain death with a parent, the first disclosure of a diagnosis of cancer, or the first time admitting a medical error. My resolve to pursue a career in academic global health has only been strengthened as my awareness of the challenges and suffering in a place like Malawi has been heightened. There is much to be done. Many situations in medicine are foreign, not just because of the setting, but because they are encountered for the first time. This experience taught me that even though I might not feel adequately prepared for such moments, the responsibility is mine to deliver bad news sensitively and compassionately to my patient's families, no matter what the setting.