

## STRATEGIES FOR COMMUNICATING BAD NEWS IN OBSTETRICS

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### Objectives:

- 1) To define potential areas of poor communication.
- 2) To identify changing trends in medical malpractice.
- 3) To profile strategies for effective communication.

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Our improved abilities to manage patients with unforeseen outcomes during pregnancy have been aided significantly by two events: our understanding of pregnancy loss as a continuum and refinements in ultrasound which now allow for unprecedented prenatal diagnoses.

Our broader definition of pregnancy loss as a continuum to include all departures from normal fetal and newborn development has enabled us to recognize that patients with a variety of perinatal outcomes grieve similarly. As a consequence, techniques learned from patients with stillbirths or miscarriages can now be extended to those whose babies are born with structural or genetic defects. This expanded care has opened our eyes to the needs of a far greater group than were previously appreciated.

Perinatal loss should be defined as one of the following:

1. Loss of a loved one.
2. Loss of future goals.
3. A departure from normal.
4. Loss of expected outcome.
5. Loss of living qualities.

By expanding one's definition of perinatal loss, one recognizes that the greatest significant loss is that moment when a couple learns their baby will not be normal. But departure from normal can take many forms. A stillbirth or newborn who dies is acknowledged as the simplest example of a loss of normalness. A newborn with a meningomyelocele or congenital heart defect eliminates forever the possibility that that child will grow into a normal adult with access to all society's opportunities. This

departure from normal forces parents to view the outcome of their child's life as impaired and loss of living qualities begin to erode the hopes and dreams the parents had for their child. They must confront the fact that society does not tolerate well the impaired, the deformed or the handicapped. It will be in this uncaring world that their child will struggle to succeed.

## **THE ROLE OF ULTRASOUND IN PREGNANCY LOSS DETECTION**

With the advent of ultrasonography, a major change in professional responsibility for the management of perinatal loss has occurred. In the late 60's and early 70's, fetuses with unexpected outcomes such as hydrocephaly, severe growth restriction, or structural abnormalities of the heart or kidneys were delivered without prior anticipation of these defects. The obstetrician often identified hydrocephaly while palpating widely spaced cranial tables and a soft fluctuant anterior fontanel in late labor. Abnormalities of the face or body were identified only at birth. The responsibility of management, instead of resting with the obstetrician, was immediately assumed by the pediatrician at delivery. For the parents and the obstetrician, anticipation of events seldom occurred. The parents' grief reaction focused upon the outcome of care in the newborn period. As such, the obstetrician and parents remained passive participants in this life crisis.

In today's technical environment, prenatal diagnosis and anticipation of outcome have become the accepted norms. As such, the obstetrician and patient have been placed in the unique opportunity of participating to predict outcome. For many of these planned or anticipated pregnancies, the parents now are thrust into the unenviable position of being fully advised as to the findings and of being given the responsibilities for choosing future management.

With the advent of the ultrasound laboratory as the common pathway through which prenatal diagnosis is made and perinatal management developed, a need now exists to standardize the approach for patient management in this highly technical and often intimidating medical environment. It is in this arena that an unsuspecting sonographer routinely scanning an obstetric patient discovers lack of cardiac activity in a near-term fetus, or a blighted ovum in a patient anticipating a successful in-vitro fertilization. It is here that a patient at 38 weeks' gestation first reads in the face of the sonographer that her fetus has died. It is also in this area that many questions arise but few are answered in any standard format. What should be said first to the parent when a major fetal anomaly or intrauterine death is discovered? Who should relay this information to the parents? How should the counseling follow once the diagnosis is made? What will be the reactions of parents when, over a period of only minutes, they are taken from anticipating a healthy child to the death of their child and loss of future plans? Can the emotions of the couple truly travel quickly enough to make this transfer as the sonographer or physician in the ultrasound laboratory doles out the facts which represent the interpretation of the ultrasound findings?

Picture the worse scenario:

No fetal heart rate is detected in office.

"We'll send you to ultrasound (same day, next day?)."

At ultrasound laboratory:

Patient sits with other pregnant women.

Sonographer scans quickly, but says little. Then she gets physician.

Physician:

Also performs a brief scan.

The ultrasound machine is switched off.

"I see no heartbeat. The results will be sent to your doctor."

Patient wonders:

"Is the ultrasound machine bad?"

"Does the doctor need glasses?"

"Is there something wrong with my baby's heart?"

Patient leaves fearful, angry, frightened and confused.

The proper approach to these couples requires an appreciation of the emotional toll that a pregnancy loss has upon the family and the medical skills which integrate psychosocial counseling with education of medical facts in order to meet the needs of these patients. The following principles have been utilized in our Perinatal Ultrasound Laboratory at the University of Rochester and have proved invaluable in establishing a level of confidence between physician and patient while avoiding misconceptions and miscommunication.

**Duration of scanning:** Even though with current technology a diagnosis often can be made within seconds after the ultrasound transducer is placed on the abdomen of the patient (such as if the fetal heart is not beating or if there is over-riding of the skull bones), the sonographer or physician should continue to scan while acknowledging to the patient that "over the next couple of minutes we'll be examining all parts of the baby before we draw any conclusions." In this manner, the patient is politely informed that a thorough ultrasound scan was performed if, following the examination, a diagnosis of intrauterine fetal demise or fetal anomaly is made. When a very brief or cursory scan is performed followed by a remarkable diagnosis such as intrauterine fetal death, the patient often is left with the uncertain feeling that perhaps the physician made a mistake or the ultrasound machine was not properly calibrated.

**Acknowledge the event:** If the diagnosis is clear, most physicians struggle with that first descriptive statement. In the absence of a more appropriate first sentence, I usually say "I am sorry but we have detected a major problem which I need to tell you about." At that point, if I am certain of the diagnosis, I will state the diagnosis in the most clear and simple terms possible. With a diagnosis such as intrauterine fetal death or hydrocephaly or other life-threatening condition, parents seldom will hear much more than those few first words. It serves no purpose to begin a lengthy discussion of the findings since the shock of this information seldom allows parents to understand or be able to ask questions.

**Show ultrasound screen to parents if they wish:** Before the woman is asked to move from the ultrasound table to a conference room, the couple should be asked whether they would like to see what we are seeing. Many parents will, in fact, request this, even as they are weeping or expressing great grief. If they choose not to see the ultrasound findings at that time, this is an option which can be offered later.

**Remain with the couple:** In our ultrasound laboratory, the couple is taken across the hall to a private consultation office, where there is a phone. I usually sit with them for about 10 minutes explaining the findings in simple terms. I ask if there are immediate questions but acknowledge that under the duress of the moment it is common not to be able to ask appropriate questions.

**Allow parents private time with a phone access:** At this point, the couple is usually left by themselves for approximately 5 to 10 minutes. It is during that time that I call their private physician and relay the information of the findings. If the couple wishes, but is unable to make a personal phone call by themselves, I will often make that phone call for them in order to relay these findings to family members personally chosen by the couple. I then return to the couple and, while sitting quietly with them, ask whether they have questions and again ask whether they would like to see their baby on the ultrasound. Couples who initially have refused to see the ultrasound screen will, on occasion, request to see the films or the results of real-time scanning at this point in the consultation.

**The couple then is allowed to return home.** I provide them instructions which I was given during my initial phone contact with their physician. It is during that part of our discussion that I offer the couple an opportunity to return the next day in order that we can discuss further questions regarding our ultrasound findings and the clinical significance. In my conversations with their private physician, I also offer this return visit as a way to remove the burden from the obstetrician/gynecologist to address the complex issues regarding the ultrasound finding and management. It is in the context of these approaches that we have learned a great deal regarding the means by which couples react to a wide range of perinatal losses. Furthermore, we have had to realize that when a more standard approach to conveying this information is developed, the medical skills provided in the ultrasound lab become more refined and sophisticated. The following pregnancy losses provide examples of how, despite differences in the outcome, the reaction of parents is often the same.

**First trimester miscarriage:** For years a miscarriage has been overlooked as a significant perinatal loss. Terms such as "blighted ovum", "vanishing twin", or "passage of tissue", while perhaps conveying some medical information from one care provider to another, often are viewed by patients as insensitive statements which deny the existence of the early pregnancy. Many couples select names for their babies in the first trimester, thereby imparting a personality to this early pregnancy. With the improved use of transvaginal ultrasound, men and women are being provided a view of their baby as early as 7 or 8 weeks. It is understandable, therefore, that when a miscarriage occurs, it is viewed by many couples as having the same impact as a late pregnancy loss. In some ways the loss is even more complicated. The couple may never know whether this was a boy or a girl and thus cannot use the names they have selected. Additionally, while the husband lacks early pregnancy sensations of nausea and breast

tenderness as proof of the existence of the pregnancy, a woman experiencing these sensations assumes complete responsibility for the outcome and may out of guilt attribute the miscarriage to such activities as having a glass of wine, or having intercourse, as her way of assigning cause and effect.

**Blighted ovum:** For most care providers, a blighted ovum represents a failed embryonic development, often associated with Trisomy 16, in which chorion and amnion develop in the absence of a fetal pole. Although this information may help the couple to understand the etiology of the loss, it must be provided to them in a sensitive way which acknowledges to the couple that the pregnancy existed and was not in fact a nonpregnancy.

**A second trimester ultrasound diagnosis of intrauterine fetal death or fetal structural anomalies incapable of life:**

In many ways, these groups of conditions can be collectively evaluated. Whether the fetus exhibits a structural anomaly such as a congenital heart lesion, or dysplastic kidneys, hydrocephaly or hypoplastic left heart, a common theme emerges. Couples, over time, can intellectually adjust to the realization that a fetus with a major anomaly may be so severely impaired as to have no chance of any quality lifestyle. If the condition is not lethal, but requires multiple major operations with little hope that the child will live a normal lifestyle, this loss of living qualities emerges as a perinatal death in its own right. For this reason, the initial diagnosis in the ultrasound laboratory often becomes the most intense and most devastating moment for this couple. These couples, with time and proper counseling, gradually come to accept the diagnosis. But even if death becomes the ultimate outcome, the greatest and deepest loss still remains that first moment when they learn that their baby is not normal and has a major abnormality. In my experience, couples who have been counseled one or two years later still recall with vivid detail the impact of that moment in the ultrasound laboratory.

With improvements in ultrasound and with our ability to diagnosis prenatally major fetal structural abnormalities, couples have been forced to make choices regarding management. For some couples, the option of termination may be selected when diagnosis of a lethal or near lethal condition is encountered prior to 24 weeks. These conditions may include such conditions as anencephaly, hydrocephaly with meningocele, bilateral dysplastic kidneys, hypoplastic left heart, Trisomy 13 or 18, cystic hygroma with ascites and renal agenesis. Following the initial diagnosis, all couples are given a similar level of counseling. If termination is selected, they are provided information regarding techniques and physicians skilled in this field. If the pregnancy is to be continued, they are told that their baby and they will be provided maximum care to prevent suffering and to provide the baby at delivery comfort, support and respect, even if death is a certain outcome. At no time are couples coerced to pursue one route over another. Instead, they are fully advised regarding all options.

For couples who appear after 24 weeks with a near lethal or lethal condition diagnosed by ultrasound, the options become more limited but equally as complex. The four options provided are as follows:

1. Allow labor and vaginal delivery to occur unmonitored. As such, cesarean section would not be carried out for fetal distress. In our experience, this option, while seemingly appropriate for many

lethal fetal conditions, is seldom chosen. From an emotional standpoint, many women cannot bear the possibility that their baby would die before delivery while they were in labor.

2. Perform a cesarean section realizing that it would not change the outcome. For many couples, this management which, ten years ago would have been considered heresy, provides them moments or hours to be with their baby before death. For those couples who have chosen this route and who have been counseled later, not a single one has regretted this choice.
3. Perform tests of fetal well-being in the rare chance that our diagnosis is incorrect and perform a cesarean section if fetal distress is encountered. In the initial phases of our experience with fetal renal disease and in many conditions which are debilitating but not necessarily lethal, this approach has been chosen by patients. For those couples in which neonatal death is the final outcome, none in our experience has regretted this choice if they had been well advised and the management clearly laid out.
4. Vaginal delivery under fetal heart rate monitoring with cesarean section as an option if fetal distress is encountered. For many conditions such as omphalocele, gastroschisis, and various forms of dwarfism where cesarean section has not been clearly defined as the appropriate route of delivery, this management program has resulted in satisfied parents and reasonable outcomes.

It is clear by today's standards, with the technologic support available, that older opinions regarding pregnancy loss must make way for newer approaches. These approaches must acknowledge loss as a spectrum influenced by technology of ultrasound and our understanding of the psychosocial impact of these types of losses upon parents. Although ultrasound technology in many ways has redefined obstetrics, the physician's rapport with his patient will never be displaced as the cornerstone of medical care.

#### **PRINCIPLES WHICH APPLY WHEN MANAGING PATIENTS IN THE HOSPITAL FOLLOWING A PREGNANCY LOSS**

These principles are based upon our assumptions: 1) that labor following an intrauterine death is unique without the rewards typically gained by delivery of a healthy newborn, 2) that the care providers are comfortable to address the issues surrounding pregnancy loss and will not shy away or withdraw due to their own feelings of discomfort, and 3) that professional resources are available to the patient while in the hospital. For example, anesthesia for labor must be planned which does not sedate with the intent to allow the patient to experience the birth, but also the grief which accompanies that birth. Epidural anesthesia once labor is effectively established appears to accomplish this goal. During labor, the care providers must be in attendance. The discomfort experienced by the patient, both physically and emotionally, often drives care providers to withdraw, leaving the patient feeling isolated and lonely. Simply sitting in the room while the patient labors may be viewed by the patient and her family as supportive and caring.

Many emotions surface as the patient and her partner experience labor for a late pregnancy loss. The patient may fear labor as a painful experience without reward. The patient also may fear the appearance of her newborn following delivery as validating her fears that the newborn will appear grotesque and misshapen.

The patient may feel guilt that activities in which she or her partner have engaged during pregnancy have resulted in this outcome. For the woman, this feeling of guilt may reflect her sense of absolute responsibility for the baby, now dead, that was carried in her uterus. The patient may feel anger, either at herself or as a protective shield against those around her. This anger may even be directed at obstetric care providers who failed to anticipate this outcome and act in advance. The patient may feel loneliness and isolation as the sensation of "why me?" surfaces. Those with strong religious backgrounds may interpret this outcome as punishment for activities that they have indulged in during their life.

### **MANAGING DELIVERY OF A STILLBIRTH**

At delivery, the care provider must be sensitive to the unique nature of this birth, in what otherwise would be an uncomplicated and joyous event when a healthy newborn is delivered. By viewing this experience through the eyes of the grieving parents, the care provider can be more effective in managing the events at delivery. The dead baby should be placed in a blanket immediately after delivery and, if possible, made available to the parents soon after. The stillborn baby should never be delivered into a bucket or pan or left straddling the delivery table while attention is paid to delivering the placenta. At times, it is appropriate to wait until the patient has been moved to a quiet room to present the baby to the family. At these times, it may be helpful if the care provider guides the parents in their initial encounter with their dead baby. Explaining the normal findings exhibited by the baby, such as the appropriate number of fingers and toes and the appearance of the arms and legs, may allow the parents to adjust to the color changes or even skin changes. Ultimately, the family may wish to view the entire body of the baby. This should be done with grace and without resistance in order that the family can be assured that their imagination of the appearance of the baby was far worse than the actual physical appearance. In the absence of obvious deformities, statements such as "You have a boy; there are no obvious abnormalities" may relax the family during these initial tense moments. During this period, conversations among care providers or with the family should be quiet, respectful and always on the topic of the newborn and not other issues. Care providers also must remember during this period that the woman and her family are observing them as they interact with the dead baby. These memories, while brief, may provide a lasting foundation for later counseling when care is provided in a thoughtful and compassionate way.

There is no rule as to how long a stillborn baby should be left with the family. Families never abuse this activity and they should be the judge as to when that time interval is up. It is inappropriate for a care provider to abbreviate that experience, possibly the last encounter between the baby and the family, because of schedules or other medical commitments. It goes without saying that the woman should be alert during this interval in which the family and the baby are together. If the woman has been

administered general anesthesia for a STAT cesarean section, the care providers may wish to wait until the effects of the anesthesia have worn off before allowing the family and the baby to be together. It is important to remember that when medical professionals view the disfigured body of a stillborn baby, that their view of the baby may be quite different from that of the parents who do not see the deformities and malformations but, instead, view the baby they hoped would grow into an infant and toddler.

## **POSTPARTUM MANAGEMENT**

Postpartum management must be consistent with that care provided during labor and delivery. The care provider should see the patient at least twice each day and, if possible, sit down for a few minutes during each visit to discuss with the patient how she is doing. When this role is not assumed by the care provider, then nurses, chaplains, and even housekeepers often fill in this gap, thereby separating the care provider even further from the role that he or she should be playing.

It is more comfortable to provide care to these patients if one understands the needs that these parents have:

- ? Parents want to believe that their baby did not die alone or lonely.
- ? Parents want to feel that everything reasonable was done for their baby for as long as he or she survived.
- ? Parents must cope with their concerns that the baby was abandoned by the medical staff or that the baby suffered with pain or cold before death.

Both parents, if offered the opportunity, desperately want to be with their baby before and, if possible, while he or she dies.

## **NAMING THE BABY**

All parents respond more favorably to care providers during these moments of crisis if the care providers use the name that had been selected for this baby. Selecting the name defines a personality. Once this name is known, the care providers should always use this name in conversation. It may even be appropriate to ask why that name was chosen. Answers to this question may provide insight as to the emotional significance of that baby within the family.

## **TAKING A PICTURE**

Photos of the dead baby provide an important foundation for resolving grief. Care providers initially may react to the appearance of a stillborn by assuming the parents would not want a picture. This is, in nearly all cases, a false assumption. When taking a photo, the care provider should consider certain techniques which make the picture more appropriate. Turning the head of the baby slightly to expose the jaw line, nose and other features of the face, as opposed to a direct front-on picture, provides a better view of the facial characteristics which can be identified by family members. Whether the eyes should be opened or closed should be addressed. Moistening the lips and placing the baby in a blanket

with an arm exposed, often softens the picture. Despite these techniques, however, many families also wish a picture of the fetus unclothed in which all of the body is available on the photo. Some parents may refuse initially to have a photo taken. In our experience, obtaining those photos and placing them in a file often results in a later request for these photos. It is not unusual at a counseling session several months after delivery, when the parent is asked if he or she has a photo of the fetus, that this photo is shown with the same enthusiasm and love that we would show photos of our own healthy family members.

## **OBTAINING AN AUTOPSY**

The results of an autopsy often will provide important answers to the question, "Why did it happen?" and "Will it happen again?". It is not unusual for a family, initially after delivery, to refuse to have an autopsy. This response most often reflects their impression that an autopsy is a disfiguring procedure that will not provide new information. With modern techniques, an autopsy can be done and yet still the newborn can be presented in an open casket at a funeral without evidence of the autopsy procedure. To obtain an autopsy, the care provider may need to spend time describing in compassionate but clear details the techniques which would be used. With these types of explanations, the family may come to recognize the importance of the autopsy and thereby agree when they initially refused to have this carried out.

## **POSTPARTUM ISSUES**

Breast engorgement is a common postpartum problem for families who have experienced a stillbirth. Counseling may help to reassure the woman that this is a physiologic response even as she views this response as a reminder of her dead baby. Although it is customary for a nurse to instruct a maternity patient about breast management, this issue may be overlooked or even avoided by care providers following a fetal or neonatal death.

## **MANAGEMENT OF THE PATIENT AFTER DISCHARGE FROM THE HOSPITAL**

In my experience, the most important decision that must be made in providing outpatient care for these patients is when to see them first in the office. My recommendation is that the first visit occur no more than one week to ten days out from delivery. While some care providers may argue that this is too soon, the one-hour session that usually is required often devotes itself exclusively to the first night in which the family returned home. Was the nursery dismantled? Were family members present, and could they help the couple cope with their grief? If there were siblings, how did they react? What support systems are in place for the woman and her partner? What nightmares or misconceptions exist which must be addressed to avoid anger and further confusion as time passes without resolution of these issues? When one waits until six weeks to see the patient, a family struggles unaided and uninstructed to find answers to their many questions. When care providers fail to provide these answers, well intentioned family members, friends, or lawyers can find answers. Bringing a patient back in the first week after delivery provides an important foundation for future counseling sessions and demonstrates

unequivocally that the care provider is not disinterested, or uncomfortable with conversations about the dead baby.

During this and subsequent sessions, the care provider may seek to explore painful or frightening feelings which the patient and her family have encountered. Questions which the care provider may wish to ask, but are not comfortable to ask are:

- Are you angry at me for not doing something sooner?
- Do you feel that I should have done more to identify the problem?
- Do you feel that I caused this?
- Do you think that I may have overlooked something?

These questions may be addressed in a more neutral manner as follows:

- You seem angry; can you tell me what it is caused by?
- Some couples at this point are very angry, do you have these feelings? If so, where are they directed?

It is understandable that you might feel angry or frustrated that more should have been done or that something should have been done earlier. Do you have these feelings?

Questions like these, on occasion, will bring direct verbal assaults on the care provider. Nonetheless, it is better to bring these feelings out early in the recovery phase, as opposed to waiting weeks or months until these feelings become the foundation for a more confrontational relationship between care provider and patient.

### **QUESTIONS TO ASK AT FIRST OFFICE VISIT**

- How did they treat you in the hospital?
- Should more have been done to help you then?
- How did it feel to go home?
- What was the hardest part for you?
- Have you had awkward encounters?
- What were the responses of family members?
- How did your husband's co-workers react?
- Have similar past events occurred? How did you respond to them?
- Who is your main support person?
- What do you think caused your baby's death?

### **FEELINGS GENERATED BY ENCOUNTERS WITH FRIENDS OR ACQUAINTANCES**

There are many common responses by family members once they enter back into the community following a pregnancy loss. "My family and friends avoid me." This is a common response by caring friends who feel inadequate to ask obvious questions such as "How are you doing?". While a care provider may not be able to control these events, counseling the family that these encounters will occur often preempts a negative reaction by the family. "I run into friends or acquaintances that are unaware of my pregnancy loss." This encounter often happens at a mall or other public facility. Forewarning the

couple of these events may allow them to develop in advance a standard response, as opposed to being caught off guard.

## **DIFFERENCES BETWEEN MEN AND WOMEN**

Men and women respond differently to pregnancy losses. It is common for a brief period of days or even weeks following a loss, that both the man and woman will respond similarly to the grieving process. Shortly thereafter, however, each begins to recover in a different pattern. Men tend to recover more quickly and as part of this process will engage in more activity, whether that involves taking on more work or the acquisition of new hobbies to keep them busy. Women, on the other hand, will recover more slowly with specific setbacks. At six months, on the date of the estimated date of delivery, at one year, and even at two years, the woman may experience a dramatic reoccurrence of her grief feelings, even as she is beginning to find more of a normal pattern to her activities. Providing couples this information will help them respond to these emotional changes, as each recovers at a different rate and in a different pattern.

## **WRITING A LETTER**

It is often helpful in the early days or weeks following a pregnancy loss for the woman and her partner to be encouraged to write down their feelings in the form of a letter or journal. These feelings, captured at a point in which their awareness of their inner thoughts are most vivid, provide documentation forever that they love their baby and that this grief is real. For some couples unable to initiate this practice, the care provider may wish to start a letter such as “*Dear \_\_\_\_\_, Your mother and I had made a lot of plans for your future that I wish to tell you about.*” This letter may be a paragraph long when completed or it may be several pages. What is common to all families who engage in this activity is the fact that they never throw these letters away. The letter, along with the pictures, blanket, wrist band, and other mementos provide sound evidence that pregnancy loss is a major life trauma, generating some of the most profound emotions in life. It is only when care providers recognize the invaluable role which they can play

in the care of these families that they can appreciate what was written in a poem by Robert Browning Hamilton:

I walked a mile with pleasure  
She chattered all the way;  
but left me none the wiser  
for all she had to say.  
I walked a mile with sorrow  
and ne'er a word said she;  
but, oh, the things I learned from her  
when sorrow walked with me.

In summary, pregnancy loss is an obstetric responsibility. Pregnancy loss management has structured format and its implementation by care providers demonstrates that medicine remains a noble and compassionate art.

## **THE ‘FEARED’ FACTOR**

Adapted from What Do I Say and How Do I Say It? Communicating Intended and Unintended Events In Obstetrics

Editors James Woods, Fay Rosovsky

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Most house staff and attendings share a sense of apprehension when they are about to engage in a conversation with a patient about an unintended, adverse outcome. Few were educated in this form of communication. In fact, most would acknowledge that they never had a formal lecture on the art of delivering bad news, either in medical school or residency. Their skills, whatever they are, may be drawn from anecdotal cases where a more senior care provider permitted them to attend while such a conversation occurred. Fewer even, as young care providers, have experienced personal tragedy, whereby the care provider (or family member) becomes the care receiver.

The apprehension felt by care providers in anticipation of such a communication may actually arise from two different circumstances. There are those cases in which the care provider must deliver bad news about a medical event that was not preventable. The woman who unexpectedly is diagnosed in the ultrasound laboratory with a spontaneous fetal death, or the woman who develops severe preeclampsia and must be delivered prematurely, perhaps to the detriment of the premature newborn. But in this anticipated conversation, what does the care provider fear? Perhaps it is the sense of inadequacy, the inability, because of inexperience, to respond to the grief reaction, the tears, even the outrage. What is the next sentence which should follow the statement, “Mrs. \_\_\_\_, our ultrasound study has indicated that your baby (fetus) has died.” Suffice to say, the phrase “I am sorry” is human, shows compassion, and provides a momentary safe harbor. But what then? Does the care provider sit in silence with the patient? Does he or she leave the room briefly (to allow the patient and partner some private time)?

What of the anxiety and apprehension felt by the care provider, faced with a bad outcome, who might (should) have carried out a different therapy that would have produced a different outcome? This situation, handled improperly, offers the most potential for legal action. Was the patient and her family aware of the risks? Did the family misinterpret events or action plans? Or, are they correct in assuming that a better plan would have produced a better outcome? And you, the care provider were responsible.

We live in a litigious world where each person has the right to seek legal counsel against his or her care provider. Some do so to cover the financial costs of short term and long term care following an adverse event. For those cases, some will be dismissed as frivolous, some will be deemed a bad outcome but

for which no one was at fault. While others will be attributed to the inexperience or bad judgment of the care provider.

But others will sue, simply because this avenue is their only means of reestablishing control over their lives. Whether out of anger or frustration, misinterpretation or family urging, these cases represent the product of ineffective communication. The young care provider may ask, “What good is it for me to talk to this family if my care really did result in a bad outcome? They are going to sue me anyhow.” To that care provider, I say “stop”. The fact that a patient experienced an adverse outcome, and that an alternative type of care might have made a difference does not, de facto, mean the patient will sue. On numerous occasions where I have been asked to intervene in a discussion between care provider and patient following an adverse event, I have heard the patient say, “I’m really angry at all of you, but at least you had the courage to meet with us. We’re not going to sue. We just wanted to see if you would be honest.”

The young care provider next may say, “I’m afraid I will get into such a conversation and lose my way, lose track of where our discussion should go and forget the issues that should be covered. In other words, is there a simple way to structure such a conversation? For those care providers, we offer the acronym FEARED, an emotion felt by care providers confronted with those situations. We believe that that this sequence of items offers such a structured approach.

Get all the **F**ACTS  
Express **E**MPATHY and **E**DUCCATE  
Search for sources of **A**NGER  
Have the patient **R**ECITE back to you her understanding of your explanation.  
Evaluate the **E**XTENDED family response.  
**D**OCUMENT the conversation.

**F GET ALL THE FACTS**

“Mrs. \_\_\_\_\_, I have reviewed your chart and hospital course and have reconstructed the events as follows.....” [A brief review of the entire case establishes a factual basis for the rest of the discussion.]

**E EXPRESS EMPATHY AND EDUCATE**

“I speak for our entire group (Department?) in saying how sorry we are for the \_\_\_\_\_.  
Medicine is an art form, not a mathematical equation. When bad things happen, it is our obligation to examine carefully the events to understand better if this could have been prevented, whether we should alter our practice and, as important, explore how we can help you and your family as you move forward. My assessment of the sequence of events is as follows:.....” [Here, an educated evaluation follows.]

**A SEARCH FOR SOURCES OF ANGER**

“Mrs. \_\_\_\_\_, after such a disturbing experience, it is not unusual for some people to feel angry. Do you have those feelings, and if so, where are they directed?” [This is the hardest question the care provider can ask. Their fear comes from feeling that if the answer is “Yes, I am angry at you,

doctor,” the care provider will lose control of the conversation. Not so! This question, phrased in the third person, may lead to a truly constructive dialog. The real issue is “What do I (the care provider) say if they state that I was the responsible person for the bad outcome?” The follow-up response is quite straightforward. “I am sorry you feel that way but it is understandable. Please tell me how you arrived at that conclusion.” [Here, the care provider must listen carefully for misinterpretations made by the patient or family members in the event that misconceptions represent the foundation of the anger but also offer the best opportunity to correct the facts. But what if they are correct? The initial statement in response to their anger is based on correct conclusion is simply, “You may be correct that a different plan would have produced a better outcome.” [See case \_\_\_\_] At this point, the care provider may only have honesty and compassion as a defense. Still, used properly, they may be sufficient to avert a lawsuit.

**R HAVE THE PATIENT RECITE BACK YOUR EXPLANATION**

As the conversation moves toward conclusion, it is most important to evaluate how well your explanations were understood. A simple question such as “Mrs. \_\_\_\_, it is very important that I know that you have understood me and the medical issues that we have discussed. Please tell me what your understanding of our conversation is and if there are any areas that we should repeat or expand.”

**E EVALUATE THE EXTENDED FAMILY’S UNDERSTANDING**

At times, the inability of extended family members to understand the sequence of events leading to a bad outcome produces a slow, smoldering anger that surfaces weeks or months later. To decrease this possibility, a direct address to the family members attending such a discussion is important. The statement might be “Many times family members feel left out when these difficult conversations are held. You all have heard our discussion. Are there issues that you feel we should cover in more depth?”

**D DOCUMENT THE CONVERSATION**

The following should be included:

1. Date and duration of conference
2. Name of care provider with titles and family members
3. A brief description of the discussion. This should include:
  - ? Facts of the case (F), outcome and tone of conversation (E)
  - ? Sources of anger (A)
  - ? Level of understanding by the patient (R)
  - ? Issues raised by extended family members (E)
  - ? That the documentation was done immediately after the meeting (D)
4. How care providers intend to follow up with the family.

In summary, the conversation to deliver and discuss bad news after an unanticipated adverse event need not be traumatic. Instead, with the proper structure, it can be turned into a compassionate, constructive dialog. Having a conversation with a family after the successful birth of a healthy newborn is easy. Offering a conversation with a family after an adverse unanticipated event draws on the most noble resources in medicine, having compassion.