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Breaking Barriers to Effective Communication of Bad News –Obstetric Outlook

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Abstract

Breaking a bad news is a difficult task that requires patience and refined communication skills, and must be approached with empathy towards patient and relatives. Patient centered communication technique is considered the best. A pregnant lady and her relatives at each antenatal visit need an assurance that 'all is well'. On occasions the obstetrician may have a bad news to communicate shattering the hopes. The field of Obstetrics is also filled with many experiences that are sorrowful, which include failure to conceive after infertility treatment, miscarriage, ultrasound detected fetal anomaly, fetus with genetic problem, fetal and neonatal demise and birth injury

Keywords: *Breaking bad news, empathetic communication, patient-centered communication technique*

Introduction

Bad news can be defined as 'any information which adversely and seriously affects an individual's view of his or her future' (1) Bad news is always, however in the eye of the beholder, such, that one cannot estimate the impact of the bad news until one has first determined the recipient's expectations or understanding .

Barriers to Breaking Bad News

The medical education has always emphasized on technical proficiency, communication has never been a part of curriculum. This leaves physicians unprepared for the communication complexity and emotional intensity of breaking bad news. (2) The fears doctors have about delivering bad new include being blamed, evoking a reaction, expressing emotion, not knowing all the answers, fear of unknown and untaught, and personal fear of illness and death. (3) Tesser and others(4) conducted psychological experiments that showed that the bearer of bad news often experience strong emotions such as anxiety, a burden of responsibility for the news, and fear of negative evaluation. This stress creates a reluctance to deliver bad news, which is named "MUM" effect. The MUM effect is particularly strong when the recipient of bad news is already perceived as being distressed. (5) An ASCO (American Society of Clinical Oncology) Survey identified several additional stresses in giving bad news. These include queries from doctors-fifty five percent ranked 'how to be honest with the patient and not destroy hope' as the most important where as 'dealing with the patient's emotions' was endorsed by 25%. Some of the factors responsible for poor communication with patients are enumerated in table-1. Finding out the right time was a problem for 10%. Less than 10% respondents had any formal training in breaking a bad news and only 32% had the opportunity during training to regularly observe interviews where bad news was delivered. While 53% of respondents indicated that they had ability to break bad news, rest thought they were poor in performing the task.

Table1. Barriers to effective communication

Health care providers	Patient	Environment
Spoken language deficiencies	Illiteracy / low literacy level	Physical
Prejudice based on diagnosis	Superstitious, religious and cultural beliefs	Long waiting periods
Excessive use of jargon by care providers, Multilingual format	Preconceived notions	Lengthy admission and discharge procedures
Unempathetic delivery of bad news		Insufficient or poor signage
Frequent interruptions		No clear designation of duties.
Preoccupation with personal matters		Poor over process amongst HP
Inefficiency or inexperience		

Approaches to Communicating Bad News

Breaking bad news demands a great deal of professionalism, patience and energy. This communication requires appropriate kind words and understandable terminology and a secondary task of assessing how the patient and family will respond to the distress. Breaking bad news is a complex communication task. In addition to the verbal component of actually giving the bad news, it requires other skills. These include responding to patients 'emotional reactions, involving the patient in decision –making, dealing with the stress created by patients' expectation for cure, the involvement of multiple of multiple family members and the dilemma of how to give hope when the situation is bleak. The complexity of the interaction can sometimes create serious miscommunications such as patient misunderstanding the prognosis of the illness or purpose of care. (6,7) Poor communication may thwart the goal understanding patient expectations of treatment or involving the patient in treatment planning.

Patient Centered Approach

Adequate training of the physician which embrace a patient–centered (8) and family centered approach not only keeps the patient at the centre but also has been shown to yield the highest patient satisfaction and results in the physician being perceived as emotional, available, expressive of hope, and not dominant (9). In a patient and family centered approach, the physician conveys the information according to the patients and patient's family's needs. Identifying these needs takes into the cultural, spiritual, and religious beliefs and practices of the family (10). Upon conveying the information in light of these needs, the physician then checks for understanding and demonstrates empathy. This is in contrast to emotion centered approach, which is characterized by the physician emphasizing the sadness of the message and demonstrating an excess of empathy and sympathy. This approach produces the least amount of hope and hinders appropriate information exchange. (9)

Discussion

- There are several accepted ways to break bad news. These methods include common format of structured listening to what the patient knows and wants to know, giving information in understandable amounts, reacting to the news, and checking for understanding. The SPIKES protocol (6, 7, and 11) is a common template and the acronym stands for Setting up, Perception, Invitation, Knowledge, Emotions and Empathy and Strategy or Summary (Table-2) This approach was designed by Walter Baile and his colleagues at a cancer centre in Houston to accomplish the following while breaking bad news
- Establishing an appropriate setting
- Check the patient s perception of the situation prompting the news regarding the illness or test result
- Determine the amount of information known or how much information is desired.
- Know the medical facts and their implication before initiating the conversation.
- Explore the emotion raised during the interview.
- Respond with empathy
- Establish a strategy for support.

Rabow and McPhee (12) proposed a model for delivering bad news called ABCDE (Table-3). The other protocols like BREAKS and PACIENTE are summarized in the table-2.

Table2. Instruments for breaking bad news

SPIKES Protocol[6]	**ABCDE** Protocol [12]	**BREAKS** Protocol [13]	**PACIENTE** Protocol [14]
S-Setting up	**A** –Advance, preparation	**B**-Background	**P**-Prepare
P-Perception	**B**- Build a therapeutic environment / relationship	**R**-Rapport	**A**-Assess how much patient knows & how much they want to know
I=Invitation	**C**- Communicate well	**E**-Explore	**C**- Invite patient to truth
K-Knowledge	**D**- Deal with patient and family reaction	**A**-Announce	**I**-Inform
E-Emotions, Empathy	**E**- Encourage and validate emotions	**K**-Kindling	**E**-Emotions
S-Strategy or Summary		**S**-Summarize	**N**-Do not abandon patient
			TE- Outline the strategy

The goal is to enable the clinician to fulfill the important objectives of breaking bad news, gathering information from the patient, transmitting the medical information, providing support to the patient, eliciting the patient collaboration in developing the strategy or treatment plan for future.

Well developed communication skills are essential in breaking a bad news. Communication skills are worthy of evaluation and development as an important component in the provision of care. (15) Without excellent empathetic communication skill, it is not able to relate to patients and families. Patient centered communication, regardless of the provider, is a contributory factor to optimal and empathetic health care. Recently, introduction of protocols does help the health provider, but is a difficult task to integrate the content into clinical practice. The skills need to be modeled and reinforced by faculty in clinical groups since communication is recognized as a competency for health provider that can improve patient outcome. (16) It is imperative to note that a quiet, comfortable and private location of dialogue should be chosen. With regards to structure, bad news should be delivered when it is convenient to the patient, with no interruption, with ample time, and in person. Ideally those receiving the bad news are given the choice to be accompanied by someone in their support network. With regard to the message being delivered, physician should be prepared, find out what the patient already knows, convey some measure of hope, allow for emotional expression and questions, and summarize the discussion. The message should be delivered with empathy and respect and in a language that is understandable to the patient, free from medical jargon and technical terminology. Going by the principles of informed consent, patient autonomy clear ethical and legal obligations to provide patients with as much information as desired about their illness and its treatment .(17)

Obstetric Perspective

Obstetrics is a field filled with joyful experiences like conception, childbirth and the growth of family. The field is also filled with experiences that are sorrowful, include failure to conceive after infertility treatment, miscarriage, ultrasound detected fetal anomalies, fetus with genetic problems, fetal and neonatal demise extremely premature birth and birth injury to name a few. These adverse pregnancy outcome may trigger emotional responses ranging from “a little disappointed “to “in shock“. As obstetrician, we can advance our practice by adopting a structured report to delivering bad news, building on the lessons of patient–centered approach. Improving the quality of communication will reduce emotional distress and enable patients and families to effectively cope with challenging situation. A key feature of bad news is that it alters patients’ perception and expectation about their future, juxtaposing the reality of their outcome with the preferable outcome that may have been. Following a stillbirth during her first pregnancy the patient may be wondering, “Will I ever be a mother?“, “Did I cause the loss?” Or “Does all life end in death?” A traumatic event may also impact the self identity of the clinician. Following a delivery where the newborn was injured, the clinician may be wondering, “Am I a bad clinician?“, “Did I do something wrong?” or “Is it time for me to leave the profession? “Kubler –Ross identified people often experience in grief: denial, anger, bargaining, depression and acceptance.(18). He observed that hope helps people engage in more constructive responses, accept the adverse event, and plan for the future. Clinicians can plan an important role in ensuring that a flame of hope is kept burning throughout the process of responding to and grieving bad outcomes.

Conclusion

Breaking bad news is an important clinical skill. Following an established protocol and integrating empathetic communication makes the difficult task comfortable to the health provider. These skills can be learned in continuing education programs. There is strong need that more training, more awareness is created about barriers to effective communication so that health care providers enhance their receptivity towards patient's queries thereby improving treatment interventions in patient care.

References

[1] Backman R. Breaking Bad News. A Guide for Health Care Professionals. Batlimore: John Hopkins University Press, 1992:15

[2] VandeKieft GK, Breaking Bad News. Am Fam Physician 2001; 64(12):1975-1978

[3] Buckmann R, Breaking bad news: why is it still so difficult? Br MedJ (ClinRes Ed) 1984: 288(6430): 1597-1599

[4] Tesser A, Rosen S, Tesser M . On the reluctance to communicate undesirable messages (the MUM effect). A field study Psychol Rep 1971; 29-651-654

[5] Tesser A, Conlee MC. Recipient emotionally as a determinant of the transmission of bad news . Proc Annu Conv Psych Assoc 1973:247-248.

[6] Baile WF, BuckmanR, Glober G,Beale EA, Kudelka AP SPIKES–a six step protocol for delivering bad news: application to the patient with cancer. Oncologist. 2000; 5(1):302-311 [PubMed : 1096 4998]

[7] Buckman RA. Breaking bad news: the S-P-I-KE-S stratergy Psychosoc Oncol. 2005; 2 (2):138-142.

[8] Fine RL. Keeping the patient at the centre of patient-and family-centred care. J Pain Symptom Manage 2010; 40(4):621-625.

[9] Schmid Mast M, Kindlimann A, Langewitz W. Recipients' perspective on breaking bad news: how you put it really makes a difference. Patient Educ Couns 2005; 58 (3):244-251

[10] Fine RL. Personal Choices-communication among physicians and patients when confronting critical illness. Tex Med 1991; 87(9):76-82.

[11] Eggly S, Penner L, Albrecht TL, et al. Discussing bad news in the outpatient oncology clinic: rethinking current communication guidelines. JClin Oncol 2006; 24 (4): 716-719 [Pubmed : 11283138]

[12] Rabow mw, McPhee SJ,Beyond Breaking bad news: how to help patients who suffer. Went J Med 1999; 171(4) :260-263.

[13] Narayanan, V., Bista, B., & Koshy, C. (2010). 'BREAKS' Protocol for Breaking Bad News. Indian journal of palliative care, 16(2), 61–65. doi:10.4103/0973-1075.68401.

[14] Pereira, Carolina Rebello, Calônego, Marco Antônio Marchetti, Lemonica, Lino, & Barros, Guilherme Antonio Moreira de. (2017). The P-A-C-I-E-N-T-E Protocol: An instrument for breaking bad news adapted to the Brazilian medical reality. Revista da Associação Médica Brasileira, 63(1), 43-49. https://dx.doi.org/10.1590/1806-9282.63.01.43

[15] Berry JA. Nurse practioners/ patient commun ication styles in clinical practice. J Nurse Pract 2009; 5; 508-515.

[16] Charloton CR, Dearing KS, Berry JA, Johnson MJ Nurse Practioners Communication styles and their impact on patient outcomes:an integrated literature review. Jam Acad Nurse Pract. 2008; 20(7):382-388. [Pubmed : 18638178]

[17] Goldberg RJ. Disclosure of information to adult cancer patient: issues and updates. J Clin Oncol 1984; 2:948-955.

[18] Kubler –Ross E. On death and dying. Macmillian: New York, NY; 1969.

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