Communication skills in Obstetrics: what can we learn from bereaved parents?

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Abstract

Communicating bad news in obstetrics is challenging. This study explores the impact of how bad news was communicated to parents following a diagnosis of stillbirth. Qualitative in-depth interviews were conducted with 12 mothers and 5 fathers, bereaved following stillbirth at a tertiary maternity hospital where the perinatal mortality rate is 5.2/1000. Data were analysed using Interpretative Phenomenological Analysis. How the diagnosis of stillbirth was communicated had a profound and lasting impact on parents. Dominant superordinate themes were Language used,

Sensitivity and Diversionary techniques. Parents recalled in detail where and how bad news was broken and language used. Diversionary techniques created a sense of mistrust especially when parents felt information was being withheld. Bereaved parents valued privacy at the time of diagnosis of stillbirth.This study highlights the importance of language, sensitivity and environment where clinicians can learn from the experiences of bereaved parents who value open, sensitive and honest communication. The results of this study highlight the importance of patient-focused communication training for clinicians.

Introduction

Obstetricians are generally associated with caring for expectant parents who are looking forward to the birth of a healthy baby. However, when an unexpected diagnosis of stillbirth is made an obstetrician and parents are faced with the distressing reality that birth will bring death. This study exploring the impact of communicating bad news was conducted in an Irish tertiary maternity hospital. Previous studies have identified that for obstetricians, caring for parents following such a diagnosis is one of the most challenging areas of obstetric practice with considerable personal and professional impact and for some, the decision to leave the speciality[1-5].

How clinicians communicate has been the focus of many programmes and initiatives in undergraduate and postgraduate medical education in recent years, recognising that good communication skills can be taught[6, 7]. A qualitative study with Irish consultant obstetricians identified that none had received any specialist training in bereavement care or formal training in communication skills.[1] The care parents receive at the time of perinatal bereavement can shape their entire grieving process and reinforces the importance of how bad news is communicated[8, 9]. Negative experiences can contribute to complicated grief for parents on top of what is already recognised as one of the most difficult bereavements[4, 10-12].

This paper examines data from bereaved parents about their experiences of communication from clinicians at the time of diagnosis of stillbirth and the impact of this communication on them.

Methods

This was an in-depth qualitative study with bereaved parents following the diagnosis of stillbirth. The

study was conducted at a tertiary maternity hospital with a birthrate of 8,500 per annum and a perinatal mortality rate of 5.2/1,000. Ethical Approval for the study was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals. (ref. No: ECM 4 (pp) 06/03/12)

Qualitative methods are used to understand complex social processes, to capture essential aspects of a phenomenon from the perspective of study participants, and to uncover beliefs, values, and motivations towards care and service provision[13, 14]. As the study focused around the common experience of perinatal bereavement care, Interpretative Phenomenological Analysis (IPA) was the appropriate methodology to capture the lived experiences of participants. As a methodology the participant is the 'experiential expert'[13]. IPA focusses on the depth and richness of data and, by their nature IPA studies have small sample sizes. Parents of babies who had received a diagnosis of stillbirth were purposively sampled from three years -2008, 2010 and 2013. This approach was taken to study parents in the first, third and fifth years following bereavement. As the primary relationship was between the maternity hospital and mothers all communication was initiated through them and they were invited to share the invitation with their partner to also participate in the study.

A semi-structured interview guide was developed by the authors based on published literature and their experience in a specialist perinatal bereavement team. A semi-structured interview guide allows a consistency of topics to be covered while at the same time being interviewee-led. Interviews took place at a location of the participants' choosing and ranged in length from 31 to 104 minutes. Interviews were digitally recorded and transcribed verbatim. Transcripts were anonymised and checked against the original recordings for accuracy.

The data were analysed using IPA. Data analysis is thorough and undertaken in five steps: (i) Familiarisation of the transcripts – *listening to recordings, reading transcripts, reviewing notes of initial impressions*; (ii) Preliminary themes identified – *this is done on a case by case basis; it involves focussing on key words and phrases that were coded; (iii)* Themes are grouped together as clusters*; related themes are arranged together*; (iv) The creation of a master table of themes; *which themes have commonalities or contradictions? These are then be developed into superordinate themes which are made up of subordinate themes*; (v) The integration of cases; *this is where one moves from the individual to the whole sample; moving from one transcript to the next and compare and contrast the themes – is there a pattern emerging from the sample as a whole?* [14]

The data were analysed in detail by the research team and consensus was formed on the emergence of superordinate and subordinate themes. Any discrepencies in analysis were addressed by team

consensus. Data were managed using NVIVO Version 10 (QSR International).

Results

Twelve mothers and 5 fathers participated in the study. All participants were emotional during interview; recalling in vivid detail the circumstances of receiving their diagnosis of stillbirth. Following analysis of the data four main superordinate themes emerged: Language used, Sensitivity and Diversionary techniques. Environment was a subordinate theme across the data.

Language used:

Parents were able to recall the language and words used by clinicians at the time of diagnosis. Parents expressed how some phrases remained with them. Phrases that impacted on parents were those that gave great comfort and those that were upsetting. Parents appreciated clear and unambiguous language when used sensitively.

"He(Dr) literally did a two second scan and said 'I'm very sorry'. Everyone was in shock there was no warning. Dr X had no warning either, he had no idea …" (Mother, 2013)

Parents were impacted negatively by language that was cold or lacking in empathy.

"…finally a consultant came and confirmed and said 'I'm sorry but there's no heartbeat' … it wasn't in any caring way. It was like matter of fact 'there isn't, there's no heartbeat'. I didn't think it was good … he was doing a job and that was it." (Mother, 2010)

A good example of clear unambiguous and caring language was

"I'm really sorry, your baby has died". "She (Dr) was very clear and precise with her words, as in I was able to understand her … I understood everything clearly and I felt there was no stone unturned". (Mother, 2008)

Sensitivity:

The sensitivity of how news was broken to parents was recalled as part of the overall memory of experience. Parents appreciated when clinicians spent time with them in an empathic way.

"the consultant was the one that always looked after me…he told me exactly what would happen, how things would happen." (Mother, 2010)

Likewise when a clinician was insensitive it caused hurt and upset to parents. One mother was very upset when recalling her relationship with her consultant obstetrician. She was angry at how she had received bad news and was unable to express it verbally beyond the euphemism of "I don't think that doctor is a people's person". (Mother, 2008)

She did not return to that obstetrician.

In another situation a medical student caused upset by asking what a bereaved parent considered to be inappropriate questions in the birthing suite while she was in labour.

"Was this (pregnancy)… planned or unplanned?" (Mother, 2010)

Parents appreciated when clinicians communicated clearly but with compassion. For one mother this was experienced in contrast between two clinicians involved in her care. In marked contrast one clinician was "unnecessarily cold" in being very definite and absolute about a baby's life span *in-utero* following the diagnosis of a cardiac anomaly. How the information was communicated was experienced as uncaring whereas the second clinician gave the diagnosis and probable outcome but was "gentle and kind" and this was experienced as supportive by the parent concerned. In this particular case the baby outlived the 'definite survival date' given by the first clinician creating a sense of mistrust in the clinician-patient relationship.

Diversionary Techniques:

Parents identified various diversionary techniques used by staff when they became aware of a diagnosis but were unable or unauthorised to communicate the information to parents. This created a sense of mistrust when parents felt that professionals were withholding information. Parents recalled clinicians saying things like

"Maybe this (ultrasound) machine isn't working…" (Mother 2013)

Parents when they realised themselves that something was wrong were perplexed when the clinician making a diagnosis could not communicate it to them.

"He (Dr) was lovely … he was really going all the way around trying to avoid … it was very clear, he didn't even have to tell me. We could see baby … he was literally floating … he (Dr) was saying 'I need to get a second opinion'" (Mother, 2008)

For one couple they had suspected that something was wrong during two routine scans and were asked to come back two weeks later to meet with a consultant obstetrician. When they arrived for the consultation

"he (Consultant) kind of said 'listen, this is the situation' and I felt like saying 'you've known this for a couple of weeks and haven't told us'". (Father, 2010)

In addition parents were also impacted by the environment where they received bad news. The importance of privacy, single room accommodation and space to grieve was appreciated by all parents. When parents received bad news in the company of other expectant parents it made the experience more difficult and traumatic. One mother said

"I could hear other women with their heartbeats obviously. I found that hard". (Mother, 2010)

Discussion

This study brings to light the lived experiences of bereaved parents and how the care they received at and following a diagnosis of stillbirth impacted on them. The data reveals how lack of sensitivity or inappropriate language can leave a lasting impact. In addition the data also demonstrates how caring experiences are remembered in a positive and supportive way. The experiences of parents affirm findings in the literature about the importance of good communication when bad news is being given[4,10]. The importance of communication skills for clinicians as highlighted in these data demonstrates the key role such interactions have in the overall experience of parents during a distressing time. Clinicians cannot change the news they must convey but they can change how it is communicated and how they express care. This study highlights the importance of paying particular attention to the use of language, terminology and the context of how, when, where and by whom news is broken[6, 7].

One remaining question is the lack of continuity in care when the professional making a diagnosis is not empowered or authorised to communicate this to parents. In most settings it is likely to be a junior clinician who makes an initial diagnosis. This challenge is yet to be addressed and is one that causes distress to parents for whom waiting for a second opinion is difficult. Previous studies have highlighted the importance of sensitive bereavement care, staff education, the provision of appropriate facilities and a hospital-wide approach to standardised care for bereaved parents and their deceased baby[9, 15]. Following

this study, an annual multidisciplinary communication workshop in breaking bad news now takes place in the study hospital in addition to the provision of dedicated private diagnostic facilities, birthing area and counselling rooms and a dedicated multidisciplinary bereavement support team.

The strengths of this study are that the in-depth qualitative approach brings a rich level of data to inform clinical practice and learning material. The lead and senior authors contributed to the development of a national perinatal bereavement care guideline launched in August 2016[16]. The limitations of the study are that it is context specific and focuses on one particular group. Each participating mother was initially contacted by a bereavement and loss specialist midwife who was known to her. This may have influenced the participants in their agreement to participate. In keeping with similar studies following stillbirth there was a lower response from bereaved fathers (42%)[8,9]. One possible reason for this lower participation by fathers was that they were recruited through their partner.

None the less, this study brings depth and meaning to how communication impacts parents when they receive a devastating diagnosis in pregnancy. The findings highlight the key areas of language, sensitivity and honest open communication in place of diversionary and confusing terminology. The data from parents moves the insights of communication training to the lived experiences of parents who after all are the experts in their grief.

Conflict of Interest

The author confirms no conflict of interest

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