Short communication

Breaking bad news in obstetrics and gynecology: educational conference for resident physicians

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Summary

To educate the Obstetrics and Gynecology residents about how to conduct conversations about poor prognoses, a panel discussion was scheduled, with patient-educators teaching about their experiences receiving bad news. The resident physicians reported that this conference format was an effective method for teaching this content. The patient-educators appreciated assisting the physicians, were comfortable in the conference setting, and reported a willingness to return for conferences in the future.

Keywords: Resident education; bad news; perinatal loss.

Introduction

The need to communicate bad news and poor prognoses is commonplace in women’s health care, as in the case of new diagnoses of cancer, informing of severe fetal malformations, or when treatments have been exhausted for life-threatening diseases. Discussions with patients regarding poor prognoses are difficult, both for the patient and the physician. A panel discussion conference was organized utilizing patients as educators, to discuss how to impart bad news to patients with respect and compassion.

Methods

A panel discussion was offered to the Obstetrics and Gynecology resident physicians. Three former patients served as patient-educators, and spoke about their personal experiences receiving bad news. After the conference we conducted a two-phase evaluation process, requesting feedback from the residents about the usefulness of the educational experience, and from the panelists about the impact of presenting to the residents.

The panelists were selected from the counseling practice of the author. The panelists offered to create a document, “Pearls of Wisdom” (see Table 1), that they would have hoped their physicians had utilized. We met in a private room, around a large conference table. After introductions the panelists spoke for ten minutes about their experiences.

The panelists included Patient Educators A: 35 year old couple who were telephoned by their obstetrician and told that the amniocentesis results indicated that their baby had Trisomy 21. The physician introduced the bad news by saying, “I’m sorry, the results were not what we had hoped.” They were referred to a pediatric cardiologist for an evaluation of the baby’s heart, and informed that the heart had anomalies. They elected to terminate the pregnancy, and were relieved that their obstetrician sent them a sympathy card, and telephoned one year after their loss, remembering the anniversary.

Patient Educator B: 47 year old woman who had been diagnosed with ovarian cancer 7 years before our conference. She had identified the mass, and consulted her gynecologist, who scheduled an ultrasound. The ultrasound technologist summoned the gynecologist, who came to the ultrasound suite. When the patient became very upset and began to hyperventilate, he instructed her to “get a grip on yourself”. He also discouraged her from completing the papers for a home loan, saying “I wouldn’t do that if I were you”. Her response to that advice, she recounted, was to “lose all hope”. She was referred to a gynecologist oncologist, and has not heard from her physician since that time.

Patient Educators C: 40 year old couple who had an obstetrical ultrasound due to vaginal bleeding in pregnancy. The technologist was silent during the examination, and called a perinatologist to review the scan. Without introducing himself, the perinatologist reviewed the ultrasound, and informed them “there is something wrong with your baby’s brain”. The couple requested a second opinion, and a second perinatologist came to them, introduced himself, informed them that he was going to look carefully at the scan and warned them that he would be very quiet. After studying the ultrasound he stated, “there is a brain malformation which might have been caused by a number of factors, but which ever it is, it is bad”. He assisted them to telephone their obstetrician, who discussed their options with the couple. The second perinatologist
Table 1. Breaking bad news: “Pearls of wisdom”

1. Arrange to have enough time to share the news without interruption
2. Pace the giving of information to what the patient can handle
3. Consider having printed information that addresses common questions
4. Deliver the Bad News ASAP. However, do NOT call the patient at work
5. Say you are sorry for their bad news
6. Never say “I know how you are feeling” unless you have personally experienced what they are experiencing
7. Include the spouse, partner and family members as the patient wishes
8. Non-verbal comforting gestures are often appreciated
9. NEVER leave a telephone message with bad news
10. Do not take away hope

also escorted them to the parking lot when they were ready to leave.

After the Patient-Educators’ presentations, the residents had several questions, such as “Was it OK to call patients with bad news?” The panelists responded, “Yes, but don’t leave it as a message on the answering machine, and don’t call at work.” In terms of what was helpful for them during their waiting period between hearing the bad news and making decisions about their pregnancy or surgery, the panelists volunteered, “Talking to family, and being referred to a counselor and support group.” The residents were curious about how to let patients know that they remember their babies/losses? The panelists suggested “Create a tickler file in your office so you can send a note a year later, and write the baby’s name in your chart, so you can refer to the baby by name”. The residents also asked about the element of hope, and how they should present it when informing patients about bad news. They were advised to talk with their patients about statistics, and recommended they speak about the percentage of patients who survive, thereby helping the patient to begin to balance their hopes and fears.

In the discussion, Patient-Educators C talked of the compassion they felt from the second consultant. They shared that the “magic ingredients” that he demonstrated were taking a moment to introduce himself and to talk to them briefly before the exam, having eye contact, and the warning about being silent during the scan. This helped them manage their anxieties. They also spoke of his encouragement that they ask questions after receiving the bad news, and also of his walking them out of the clinic.

The panelists advised the physicians to talk with their patient with the partner present if possible, to pace their conversation and take cues from the patients about what they can take in and whether they need a break. They cautioned the physicians from saying “I know how you feel”, encouraged them to stay in contact with the patient even after referring to a specialist, and to refer to support groups and counseling.

**Results**

After the conference, a questionnaire was emailed to the residents, eliciting feedback about the format, and the transferability of the content to other clinical situations. An open-ended question, “what feedback do you have about this conference?” invited general critiquing. To assess the impact of participating on the panelists, they were telephoned three days after the conference, and feedback about their experience in the conference was obtained.

Twelve residents had attended the conference and ten returned the questionnaire, with a response rate of 83%. Comments from the resident physicians were unanimously positive. One resident wrote, “This conference should be mandatory”. They indicated that they will pay more attention to the partners and family members while delivering bad news. They also stated that they learned the value of staying in touch after giving bad news. Several residents appreciated the opportunity to “practice giving bad news” with the panelists. All residents indicated that the information was transferable to other clinical situations and offered comments including: “Patients need our partnership and commitment to them”, “Made me more aware of the importance of what we say, and how we say it”, “It is important to be honest, but not eliminate hope”.

The panelists’ feedback included appreciation for being able to tell their stories in the conference setting, and to feel that their painful experiences might be of benefit to future patients. All of the panelists acknowledged discomfort with revisiting their painful experiences. However, this appears to be balanced by the sense of being helpful to the doctors. All of the panelists indicated that they would come back and do it again, if we wished.

**Discussion**

The need to communicate bad news is an aspect of providing health care for women (Chisholm, 1997). Suggestions from the literature for breaking bad news include ensuring privacy and adequate time to conduct bad news conversations, encouraging patients to express their feelings, and providing information about support services (Baile et al., 1999; Girgis and Sanson-Fisher, 1995; Ptacek and Eberhardt, 1996). Skill building is necessary to develop comfort and expertise in delivering bad news. Educational programs may assist physicians to feel more competent and to conduct these conversations with empathy and compassion. Utilizing patients as educators is a unique educational model, with patients sharing their experiences and wisdom, thereby assisting physicians to become more skillful.