

Ask the Expert

Breaking Bad News in Obstetric Sonographic Practice

by Dr Scott Bowman and Kate Squibb

Should sonographers break bad news?

The answer to this question is another question – “Can you avoid breaking bad news?” We feel that it is impossible not to break bad news during obstetric ultrasound scanning. When sonographers identify foetal abnormalities or death their body language changes quite dramatically. Clients pick up on this immediately, this is confirmed by Bowman (2000) who includes extracts from interviews with clients about this very issue. Clients in these circumstances realise there is a problem. The question now becomes how is the sonographers to best deal with this situation? At worst, the client can be left in a state of uncertainty and confusion not knowing what is happening to them. At best the client will be left with a clear understanding of what is happening to them and be prepared for meeting with the referring clinician.

At the moment it would seem that many women are being left distressed and dissatisfied at the way that ultrasound scans are handled in cases of miscarriage (Moulder 1990). Oakley, McPherson & Roberts (1984) found that distress to women undergoing miscarriage could be reduced by considerate treatment from medical staff. Franche (1997) has stated “...the patients’ recognition of the loss is eased if she is informed of this at the time of the scan”

Why breaking bad news is hard?

Ptacek and Eberhardt (1996) define bad news as “...news is bad to the extent that it results in a cognitive, behavioural, or emotional deficit in the person receiving the news. Robert Buckman (1990) gives us the following list of reasons why breaking bad news is difficult:

- Fear of causing pain
- Sympathetic pain
- Fear of being blamed
- Fear of the untaught
- Fear of saying “We Don’t Know”
- Fear of expressing emotions
- Own fear of illness/death
- Fear of medical hierarchy

We think that most sonographers can clearly relate to this list. However, it must be remembered that Buckman was writing from a medical profession perspective. We think that there are some particular reasons why breaking bad news is difficult within the field of medical ultrasound these include:

- Clients are aware that there is a problem
- Medical hierarchy

- Culture
- Lack of time
- Lack of training
- Lack of knowledge

Unlike some areas of radiographic and medical practice the client will know when there is a problem. The body language of the sonographers will give the game away. The client will often start to ask questions at the same time that the sonographers identifies the abnormality.

From interviewing sonographers, it was found that fear of the medical hierarchy is a major issue. Sonographers often report that they are afraid of “stepping on the doctors toes” if they tell the client too much. Some medical doctors put unreasonable constraints on sonographers by telling them not to tell the client – as already mentioned, this is impossible due to the intimate nature of ultrasound examinations and non-verbal communication. Sonographers should have the autonomy to be able to inform clients for their findings.

Culture is also a major issue in terms of breaking bad news. Many sonographers come from a medical imaging background. As part of their socialisation into radiography they learn that they are not allowed to tell clients any

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information about their condition and that this is the role of the medical doctor. When they become sonographers, the culture and socialisation within radiography does not equip the sonographer well for their new role.

Sonographers work under server time constraints with appointment times of between 15 and 30 minutes. Other health care professionals may have much longer to deal with this difficult situation. Sonographers do not have this advantage. Sonographers don't have to become counsellors to be able to break bad news. They need "breaking bad news" skills. Performing this task well need not take an excessive amount of time.

Traditionally sonographers have not been trained how to break bad news. Most sonography courses do not include this important aspect of practice. It is hoped that in the future this will change. Moulder (1990) makes the point that "Ultrasound is a developing field and there have been rapid technological changes in recent years. It is as if the necessary human skills have not kept up with the technological expertise". It is hoped that in the future the human side of sonography will become a much more prominent aspect of sonography education.

Sonographers are experts at diagnosis and image interpretation. They are often not quite so expert in the field of prognosis and treatment. Often clients will want to know what will happen after an abnormality is detected and the sonographers simply will not know. This leads to reluctance on the part of the sonographers to break bad news.

Are there any guidelines for dealing with pregnant clients at a time of loss?

The Stillbirth and Neonatal Death Society SANDS (1995) have produced an excellent set of guidelines for professionals working in the field of pregnancy, loss and death of babies. These guidelines give the following principles of good practice:

- Clients should be able to feel in control, and should be supported in making their own decisions about what happens to them and to their baby. Care should be parent led.
- The care given to parents should be responsive to their individual feelings and needs
- Parents need information
- Communication with clients should be clear, sensitive and honest
- Parents should be treated with respect and dignity
- Parents loss should be recognised and acknowledged their experience and feelings validated
- Parents need to be given time
- All those involved should be well informed

These are good principles to guide the sonographers but they must be formulated into policies that are relevant to the sonographers.

How do sonographers go about breaking bad news in practice?

From observing and interviewing sonographers and clients, we have identified four different strategies that are used to break bad news to clients these are:

1. The sonographer gives the client all the information they have and that the client wants to know.
2. The sonographer gives limited information and then a sonologist confirms the findings and tell the client.
3. The sonographer says nothing and asks a sonologist in to break the bad news.
4. The sonographer says nothing and the referring clinician gives the bad news at a later time.

We feel that the first two of these strategies are good. They do not leave the women in a state of uncertainty for any length of time. In our opinion strategies 3 and 4 are not so good. These strategies lead to the women being left in a state of uncertainty for varying periods of time. There should be a move away from strategies 3 and 4 towards 1 and 2.

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Kohn and Moffitt(1992) succinctly describe how the way in which a person finds out about their loss can have a long lasting impact:

“If your loss was mismanaged by a medical professional – whether a hospital nurse, your obstetrician, a sonographer, or child birth educator – you may be further traumatised and your mourning impeded...You will probably remember forever the way you learned about your pregnancy loss.” (pp161)

How should I go about breaking bad news?

Buckman (1990) may give us some pointers on how to break bad news. He has set out a six-step protocol, which is as follows:

- Getting started
- Find out how much the client knows
- Find out how much the client wants to know
- Sharing the information
- Responding to the clients feelings
- Planning and follow through

This protocol gives some useful pointers for the sonographers but does not address some of the particular issues faced by sonographers.

From the research that we have undertaken which involved observations of and interviews with clients and sonographers we have come up with the following recommendations. They are based on the following 4 guiding principles:

- Be empathetic

Try to put yourself in the place of the client. What would you want to know? How would you want to be treated? How would you feel?

- The sonographer should have the autonomy to reveal results to the client.

When a fetal abnormality is detected it is a critical life-changing event for the client. This is no time for the health care professional to be worrying about their relationships with other health care professionals. Sonographers should clearly have the authority to reveal results of the ultrasound examination in a manner that is based on their professional judgment findings (Moulder 1990, Kohn & Moffitt 1992, Franche et al 1997).

- Information should be communicated sensitively, clearly and quickly

- The bottom line should be that what ever is done is for the good of the client.

There should be a client centred approach to breaking bad news. Actions that are taken should be in the best interests of the client.

From these guiding principles the following guidelines have been developed:

· Explain the procedure before starting and mention that you will be concentrating!

Briefly outline the examination. Mention that you will be checking that all is well with the baby. Remember that many clients see ultrasound examinations as a social rather than a medical event. By mentioning that you will be checking that the baby is well this may well help prepare the client for an abnormality being found. We have also spoken in this article about the power of non-verbal communication. Often when sonographers are concentrating the client misinterprets this seriousness for abnormality detection. A brief mention of this before the scan begins will avoid this.

· Make an assessment of the client - do not treat all clients the same

It is wrong to assume that all clients should be treated the same. All clients should be treated as individuals with care being delivered to meet their special needs. For more on this issue see Bowman (1993).

Ask the Expert (cont'd):

- **Use client appropriate language, with cues taken from the terms the client uses.**

Part of the assessment will involve an evaluation of the client's level of language, knowledge and understanding. The communication that follows should be based on this evaluation. For some clients the use of technical language will be inappropriate while for others who are very well informed this might be acceptable. Euphemisms, jargon and acronyms must be avoided as it is foreign to most patients (Campbell 1994, SANDS 1995, Lalos 1999, Rabow & McPhee 1999). Care should be taken with the terms foetus and abortion – many clients object to these terms because of their negative connotations.

- **Communicate in a compassionate, respectful and empathetic manner.**
- **A support person if available should be present, if the support person is the partner be aware they may be deeply affected by the diagnosis**

If the client wants to bring another person into the scan room they should be allowed to do so. This person will often be able to offer support to the client at times of distress. However, the sonographer should be aware that if the support person is the client's partner they too may be deeply affected by the diagnosis.

- **Answer questions as fully as possible but make boundaries clear to clients**

If the client asks questions these should be answered honestly to the best ability of the sonographer. The client may well ask questions about treatment and prognosis which is outside the remit of the radiographer. In this case the sonographer should make it clear that they cannot answer the question, but the client should be informed where they can get answers to the question. It might be a good idea to give the client a pen and paper so that they can note the questions that they want to ask the referring clinician.

- **Ask if the client wants to see the scan and if they do explain**

If the client wants to see the screen this should be allowed. Based on the sonographer's assessment of the client the abnormality may be explained pointing out features on the screen. "Social" photographs should be taken and put on file in case the client wants these at a later date.

- **Don't rush.**

There are, of course, time constraints on the sonographer and extensive time cannot be spent with the client. However, this is a situation where you may want to take more time than normal. You should endeavour to keep other clients informed of the wait that they can expect. It is good practice for departments to have a quiet room where clients can wait. If helpers are employed in the department these should be trained to support clients at these times.

- **Preface relating of news with "We are sorry, we have some bad news", or similar.**

This shows your human side and demonstrates empathy with the client. It is not unprofessional to show emotion.

- **Have referral mechanisms planned and ready. The client must know what happens next**

You should be able to tell the client where to go next. The client will need to know where they can get their questions answered. Clients should not be put into public waiting areas. Interviews with clients who have gone through this type of experience has demonstrated that placing them in a public waiting area can have a long term negative emotional impact on clients. Moulder (1998) feels that bad waiting area arrangement in ultrasound departments lead to the feeling of abandonment and alienation of women.

- **Be aware that you may find this experience emotionally draining - if necessary, seek support.**

Breaking bad news is probably the most demanding aspect of sonographic or radiographic work. Sonographers should be aware that this work could be emotionally draining. Departments should consider setting up a group to discuss how breaking bad news has been handled. This would also have a very positive impact on client care in the department. Special care should be taken with novice sonographers and support networks should be made available.

Ask the Expert (cont'd):

Is there any research work taking place in this area of practice?

At present, we are undertaking further research in this area. Kate Squibb is undertaking action research with client groups in Tasmania. We hope that this work will lead to a definitive set of guidelines, which can enhance practice. Scott Bowman is looking into women's experiences of having ultrasound scans for ectopic pregnancy. We still have a lot to learn about this fascinating and demanding aspect of sonography. If you have an interest in this area and would like to get involved with the research why not get in contact!

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