

## The sting of death: a case report of breaking bad news with maternal death

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### Abstract

Maternal death stings core deep for the relatives and the service providers in an obstetric unit where they had anticipated a joyful experience from childbirth. We describe a case of death disclosure and breaking bad news in our unit. This was a case of a 34 year old, Para 1+0, who underwent elective caesarean section at term, secondary to one previous scar. The operation was successfully conducted and was discharged to the postnatal ward two hours after the surgery in stable condition. Four hours later, the patient was wheeled back to the labor ward gasping. Despite emergency resuscitative measures the patient succumbed. Death was disclosed to the immediate relative in privacy, after a summary of chronology of events, assembling a disclosure team and taking cognizance of emotional reactions. This case is presented to suggest guidelines for breaking bad news upon maternal death to minimize families' suffering from long-term emotional consequences, pathologic grief reactions and cases of medical litigation

**Key words:** Maternal death disclosure, Breaking bad news, Guidelines

### Introduction

The death of a mother has a deep seated long lasting sting for the relatives and health care providers. Pregnancy and childbirth is a normal, healthy state usually uncomplicated and fills the community with joy at the arrival of the new born. However, despite continued medical advances and technology, child birth still poses serious morbidity or mortality that more often occur dramatically and abruptly. The health care provider is thrown off guard with the responsibility of disclosing the bad news to relatives, a process that they are frequently ill prepared for, and yet requiring utmost professionalism and empathy.

To the health facility, a maternal mortality offers a litmus test to the quality of emergency responsiveness to complications of childbirth (1,2). The commonest causes of maternal mortality in Kenya are: obstetric hemorrhage, severe pre-eclampsia/eclampsia, infection and obstructed labour. Almost all of these severe morbidities are unpredictable and unpreventable, but all are treatable, if a health facility has robust emergency responsiveness (3,4).

Epidemiological studies, death review programs and clinical audits, strive to identify quality of care gaps when maternal deaths or near misses occur, to improve quality of obstetric care for future patients (2). Unfortunately, to immediate relatives, a maternal mortality is more than a mere statistic; it is a hundred percent loss to them. The clinician is therefore faced with the challenge of disclosing the bad news to the family; unfortunately there are no clear outlined guidelines in this process. The case presented highlights the challenges and suggests

effective communication strategies that can be utilized to break bad news after a maternal death.

### Case report

A 34 year old, Para 1+0, one previous scar was admitted in the labor suite for an elective caesarian section. This was conducted successfully delivering a live baby with a birth weight of three kilograms and had an Apgar score nine in one minute and 10 in five minutes. She was observed in the recovery area for two hours and transferred to the post natal wards in stable condition.

Four hours later, the patient was wheeled back to the labor ward gasping and in hypotensive shock. Resuscitative measures were instituted and she was returned to the operating theatre with a diagnosis of Primary Postpartum Hemorrhage (PPH) secondary to uterine atony. A subtotal hysterectomy was performed but the patient's condition deteriorated and she was certified dead two hours later. Staff in the theatre and the rest of the obstetric unit was left in a solemn mood. Eyes were darting around wondering who would take charge and responsibility to break the bad news to the husband who was in the postnatal ward waiting to be informed of the wife's outcome.

The following steps were subsequently undertaken:

*Patient record:* Completeness of the patient case documentation was done.

*Review of chronology of events:* A chronological review of all aspects from the antenatal period, admission into the unit, pre-operative preparation, intra-operative and post-

operative period were made by the consultant on duty together with the registrars and other service providers who were engaged in her management.

*Missing gaps identified:* It was noted that the patient had PPH during her previous caesarian section, and a re-laparotomy following that admission had been done. The details of the re-laparotomy were not clear from the discharge summary of the previous caesarian section or the clerkship of the current admission.

*Assembly of disclosure team:* The team included: Obstetric consultant on duty, senior registrar, registrars on duty in the labor ward and theatre, theatre anesthetist, theatre head matron, nurse in-charge of labour ward and the nurse on duty from the ward of admission. The team was brought together into an enabling environment for disclosure. The members of the team doubled up as witnesses to the process.

*Leadership:* Leadership in the disclosure process was undertaken by the consultant on duty.

*Introductions:* Identification with the relative as being the spouse by name and affirming his relationship with the patient was made. Self introduction by the medical personnel (disclosure team) was made. In addition each individual specified the role they played in the management of the deceased patient.

*Emotional assessment:* The spouse was notably apprehensive and asked if he could be informed what had transpired with the wife as he was called from the ward where he had been with the newborn. A chronological sequence of events of the case were provided by the leader of the team, in a language comprehensible to the relative, firm but low toned; factual and culminating to the disclosure of her death.

*Reactions:* Both the emotions of the relative and that of the health service providers were observed with the pronouncement of the finality to this patient. Of particular interest was how the spouse handled the information-pacing, crying, and questioning how he would propagate the news to his children and relatives and why God had allowed it. The leader did not stop providing reassuring and empathetic words and gestures.

*Empathy and reassurance:* The rest of the team took an observatory role but were also going through individual grieving process (tearing, silence and just being still). Upon composure he asked questions of what could have possibly happened. He also provided the vital information from the previous operation events that had happened at a different hospital. The leader provided possibilities as per the case and took the opportunity to explain the importance of conducting a post mortem. In addition, consent was sought for histopathology of specimen collected at laparotomy. He was also asked if he would like to see his wife's body. After emotional validation, it was noted he was still grappling with acceptance of the loss. Continuous empathy was shown and reassurance provided.

*Continuous support:* Enquiries on family, friends and employer were sought. The team leader made the spouse comfortable (offered tea and water) and obtained cell

phone contacts of relatives (cognizant of the socio-cultural needs) and workmates. An opportunity was further provided for the relative to ask further questions.

*Administrative aspects:* Administrative briefing of the steps to be undertaken pertaining to the deceased, the neonate and protocol for clearing from the hospital were provided.

*Resolve and acceptance:* The whole team was present for the first one hour, after which the team leader released them to resume duties in labor ward. Again the relative was asked if he would be comfortable to view the deceased body. In the presence of a small core group, he was escorted to view the body, which he confirmed as the wife. The team leader also took the opportunity to explain the tubing's that were on the body (endotracheal tube, blood giving line and ECG leads). Back in the disclosure room, he was given time to reflect while waiting for his workmates.

*Debriefing relatives/friends:* When his workmates arrived, a debriefing was provided by the team leader, the belongings of the deceased were given to them, reassurance of the state of the baby made and the protocol that they would be subsequently followed for discharge was explained.

*Closure:* After departure of the relative in the company of his workmates, a closure of the disclosure session was made by the team leader with documentation of the chronology of events in the patients' file.

## Discussion

Most labour suites are places usually filled with joy after successful childbirth, but can turn into a living nightmare for the relatives and the healthcare providers when death of a mother or newborn or both occurs. Communication of this negative alteration to a person's expectation about their present and future is deemed as 'bad news' and burdened with emotional and behavioral rollercoaster. An insensitive approach of disclosure increases the distress of recipients' of bad news, may exert a lasting impact on their ability to adapt and adjust, provokes suspicion of medical negligence and can lead to increased risk of litigation.

For the health care provider, this too is a stressful time but professionalism and empathy must prevail over and above the trauma of going through the process that culminated in death. Unlike in terminal diseases where the relatives are psychologically prepared for the death, in most maternal deaths the relatives are not prepared. Clinicians in all disciplines should be for this reason well equipped with the skills necessary to break bad news, effectively answer questions and provide support to relatives. This entails spending time to listen, hear and acknowledge the relatives emotions. In the case presented, despite provision of emergency responsiveness measures the patient succumbed. Worse still, this was following an elective caesarian section, where women rarely die. Bad news in medicine for relatives has various grades which are subjective, dependant on an individual's life

experiences, personality, spiritual beliefs, philosophical standpoint, perceived social support and emotional hardness. There are three theoretical approaches that have been used in the delivery of sad and bad news: *bluntness*: delivering the bad news without preamble; *forecasting*: preparing the recipient for bad news prior to delivery and *stalling*: is avoiding the bad news delivery. Bluntness and forecasting have been shown to communicate the news in a direct way but language styles used differ from case to case. Timing is of essence in breaking the bad news. The first phase of the interaction with the recipient has a bearing on how they will react to the news. They may display horror, shock, anger, acceptance, disbelief or denial with an overall effect on how they perceive the doctor, the news, and ability to psychologically adjust (5-7).

There are no guidelines to the best of our knowledge, available for breaking abrupt death news. Most guidelines are focused on handling patients with chronic terminal illnesses (8-12). From these guidelines and the case presented, we suggest adaptation of the following in breaking abrupt bad news upon maternal death: identify the team leader; assemble a disclosure team; set a conducive private environment; provide adequate time for disclosure; check completion of patient record with review of the case and identify missing gaps; identify the recipient of the news; team self-introduction; perform a quick emotional assessment of the recipient; disclose the bad news narrating chronologically the events culminating to death using effective communication techniques; perform an emotional re-assessment with validation of the recipient; offer empathy and reassurance; address concerns, questions, feelings and provide continuous support; allow viewing of the body if desired; address logistic administrative aspects; engage workmates, friends or relatives with debriefing and closure with documentation.

In conclusion, it is unethical to let a novice with minimal training to take leadership in disclosure of maternal death news. Recognize that doctors' own reactions to death also play an important role in this process. If information is not relayed properly, families may suffer from long-term emotional consequences and pathological grief reactions. There is need to have consensus guidelines and research in disclosure of maternal death news.

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