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Counseling Your Patients At Risk of HDFN

Announcer:

Welcome to CME on ReachMD. This activity, entitled “*Counseling Your Patients At Risk of Hemolytic Disease of the Fetus and Newborn*” is provided by Omnia Education.

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Dr. Shulman:

This is CME on ReachMD, and I'm Dr. Lee Shulman. Today I have the pleasure of talking with a true expert on HDFN and clinician-patient communication. Dr. Michelle Owens, welcome to the program.

Dr. Owens:

Thank you, Lee, it's a pleasure to be here.

Dr. Shulman:

In this program, we'll be focusing on how we, as OB-GYN clinicians can improve how we communicate with our patients about hemolytic disease of the fetus and newborn or HDFN. This includes talking about their feelings when learning about this condition and communicating with them in terms that are not medicalese or overly complex. We'll discuss using a read-back approach that both ensures she understands what was discussed and allows us to identify gaps in her understanding that can be addressed with further counseling.

As an ob-gyn with more than 30 years of clinical experience, I've always viewed HDFN as one of the more complex obstetrical issues in terms of diagnosis, management, and communication. Michelle, how do you set the stage for a discussion with your patient who probably has never even heard the term HDFN?

Dr. Owens:

Well, I think first and foremost, it's really important to reframe the narrative. This is something that patients come in very anxious about, and so I think it's important to tell patients that there may be something different that's occurring, but to kind of give them a basic overview of immunology. And that allows us, then, to kind of move into the specifics of alloimmunization HDFN.

So the first part is understanding the concept of immunity as a natural process. So this is not something that is good or bad, it's just something that is, and it's actually essential. HDFN is simply a variation of a very natural process. But in general, we as human beings form antibodies to things that are not ourselves. It is our first line of defense say, for example, against bacteria or viruses. It is a natural effort to keep us safe and healthy. So I think for people to understand that first – when you are exposed to something that is not self, your body sees it as a threat and then you have the formation of antibodies in order to protect you. In this particular variation, those antibodies recognize the non-self portion of a developing pregnancy, which again, pregnancies are part mommy, part self, and part dad, which is not self. And so that is the unique circumstance or situation that actually creates the risk. So understanding this is a variation of a normal and essential process that's very important for survival is kind of the way to set the framework.

Dr. Shulman:

You know, Michelle, I don't think I've ever heard that described more accurately than what you just said. I think too often, clinicians tend to use complicated language so as to shield them from the patient's response to the situation.

I spent 13 years in Memphis, I've spent the last 20-plus years in Chicago, and I'm originally from New York, and there are clear differences in the way people respond – the way people respond to language, the way they respond to bad news or good news.

Dr. Owens:

I think that what you said is perfect and spot-on. I've found, the longer that I've practiced, is there's more that really binds us together than really separates us. What I found is that one of the most important things for all patients to hear—irrespective of socioeconomic differences, irrespective of educational differences—mommy guilt tends to be pretty universal, and it seems to transcend any of those different categories. So the first thing that I think patients need to hear is that there's not something that's wrong with them, because they come and they feel like, "What's wrong with me?" So that seems to be something that we deal with regardless of what category, no matter whether you are in Chicago or New York, Memphis, Mississippi, California, those are all similar no matter where the patient tends to be or what their background is. Letting them know that they are not malfunctioning, that this is a natural protective response that she is actually experiencing in a different way is something that I think can be a relief to a patient and can open the door to explore some of the other things that patients are much more concerned about.

Another thing that I think is really important is asking the questions, "What have you seen? What have you read or heard about this? What concerns do you have?" And you can kind of tie in the information that you gained from your history and physical to what the patient actually responds to you to say, well these are the things that I know already, or this is what I've heard. And you kind of can meld it together in a more tailored approach for that individual patient, taking all of those things into consideration.

Dr. Shulman:

I could not agree with you more.

Dr. Owens, can you briefly describe your strategies for reinforcing your patient's commitment to monitoring the status of her pregnancy? How do you work with her to keep her engaged in the added and important surveillance?

Dr. Owens:

The easiest way for you to get buy-in, I believe, is by helping people understand why it's important. That's not something that my medical training taught me. It was just a reflection of what we asked in the third grade: "When are we ever going to use this? When is this information going to be important?" or "Why do we have to learn this?" When you have a patient with HDFN who's going to require, maybe, additional testing, more frequent visits, which reinforces the opportunity or reinforces the reality for them that there's something that's not quite routine about their pregnancy, which in turn can create more anxiety. Some people may just say, "Hey, I don't want to do that." So helping them understand why the additional surveillance is necessary. Why, whether it's additional blood draws, if it's additional ultrasounds, if it's additional visits, all of those things are important. And so sitting down and just explaining that.

I can't emphasize enough that being able to state the obvious can be so reassuring to patients, that it is an opportunity that I hope that we always take advantage of and don't skim over or miss because that can be very meaningful in creating the necessary engagement for patients.

There are lots of different types of surveillance that we do in consideration of HDFN, so if we are talking about antibody titers, explaining to them why we're studying titers, that helps us to think about how revved up our immune system is. Is your immune system kind of cool and laid back, or is your immune system revved up and ready for battle? If it's ready for battle, then that means that there's more likely that an attack is going to occur. So helping them understand in very clear terms about why we're doing what we're doing and the importance of each of those things and not forgetting to update them about where they are in the process and what we expect, or what we hope to see, I think is really important.

HDFN may be something that is happening to them, that this is actually a part of their pregnancy journey and we're going to navigate that landscape together. And that's something that I feel is really important for patients to hear and also for the providers to articulate.

Dr. Shulman:

Michelle, do you have any tips for our listeners about discussing HDFN treatment with patients?

Dr. Owens:

Sure. I think first and foremost, my recommendation would be to find common ground. If you are trying to create a partnership, it's a whole lot easier to build on a level foundation, a firm foundation. So reiterating the common shared goal of ultimately wanting the healthiest mom and the healthiest baby at the end of this process. Reiterating that for women and their families, I think, is very important

and is key in creating that foundation to establish trust that also brings people about in an engaged manner and helps them to remain compliant with recommendations and participatory in their overall care. I think that it's important to be factual but also to be positive. I think in these cases patients really need hope. Many people have scoured the internet and have found all manner of information, much of which may be misinformation and some of which could be accurate but might frame their understanding of their circumstance in a way that is really not applicable at the moment. So being able to be factual and positive is also, I think, very important when you're talking about treatment with patients.

The other thing is reinforcing the importance of the uterus as a safe place. So letting a mom know – because many people will say, “Well, why don't we just have a baby?” And the answer is, “Well, in most instances, even in the setting of HDFN, the baby may still be safer inside of you.” The risks of birth or intervention at the time of diagnosis may not actually make delivery the best choice. So I think it can be comforting and validating for women to hear that the uterus can still be maintained as a safe place and that ultimately we would like to continue the pregnancy until a point in time at which it is safest to deliver the baby.

So I think if you find the common ground, remain factual and positive, and also emphasize the significance of the uterus still being able to be a safe place, that baby's natural home, then those are things that will help to make those discussions about treatment a lot easier.

Dr. Shulman:

For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Lee Shulman, and here with me today is Dr. Michelle Owens. We're just about to delve deeper into the role of shared decision-making in counseling patients about HDFN.

Dr. Owens, you mentioned that shared decision-making is a key part of your clinical practice. Can you provide some details for our audience?

Dr. Owens:

Well, I think the importance of shared decision-making in my clinical practice is actually introduced from the beginning. So whether it's the issue of screening all the way through diagnosis and treatment, involving the patient as a full partner in their care from the very beginning. I usually start by explaining to them that their priorities supersede mine because this is their pregnancy. I am partnering with them to help get them through a certain period or through the process, but ultimately, this pregnancy with this baby is this family's experience one time. And so their goals, values, and objectives may be different than if I was the person making the decision. So my job is to guide them, to give them the tools and the information that they need to make the decisions that are most appropriate for them using their value system. And we talked about that a little bit earlier. People come from a wide variety of backgrounds. If Dr. Owens has to make that decision, her choice might be different from what the patient may choose. The recommendations may be the same, but based on our differing values, we may see them totally different. So I think that that's something to introduce very early on in the process. And I think if we did that more often, we wouldn't hear women saying so frequently that they don't feel listened to or they don't feel heard.

The other piece is that women oftentimes will feel a little bit more empowered to share their apprehensions and their fears when they feel that the forum is open for them to share those as a partner, as opposed to just going to the physician to listen to the doctor tell them what to do. So really trying to make them involved in the process, knowing that they are central to the process, as opposed to just kind of a part of it.

In my clinical practice, I have learned the importance of setting expectations for questions. And earlier in my career, I used to ask people, “Do you have any questions?” And a few years ago, I made a shift. I stopped asking, “Do you have any questions?” because most of the time, people would say, “Um. No.” And so I started asking, “What questions do you have?” And in that one moment, my clinical productivity probably slowed down because people started asking more questions, but I really got a chance to delve in and do my job. And so I have always appreciated, especially in complicated or difficult situations, being able to create an environment that sets an expectation that there will be questions. It also clues me in on to some things about my patients. I ask them, “Who's the person that you wish was here that's not here?” And everybody has someone. And then I'd say, “Well, what are you going to tell them when you go home and you tell them about this visit?” And so it gives people an opportunity, number one, to not have to be under the gun in a formal role play, but it also lets me know a little bit more about who's important to them and their support and how they would speak to or have an exchange with that individual. It's been something that's been very instrumental to me and something that I love sharing with people in hopes that it may also be of value to them.

I sometimes even tell patients that I work for them. I'll say, you know, “I work for you. It's my job to make sure that you understand,” because sometimes people are just reluctant or hesitant to ask a question. Sometimes they feel like their question is a dumb question or it's going to expose them in some way. And I think being willing to encourage them to be vulnerable and to make it part of your job, part of your business so that they're not troubling the doctor. It's amazing to me how many patients will say, “Oh, well, I was concerned about this, but I don't want to bother you.”

Dr. Shulman:

Michelle, do you have a take-home message that you'd like to share with our audience?

Dr. Owens:

An HDFN diagnosis can definitely be terrifying for any patient. The more that patients understand about their journey, the better their experience will be. And communication is an essential part of that process, and it is not as difficult as some may believe. There are just a few small points that you can incorporate into your everyday practice that really could mean a world of difference for your patient's experience.

Dr. Shulman:

So I want to thank our audience for listening in and thank you, Michelle, for joining me and sharing all of your valuable insights. It was great speaking with you today.

Dr. Owens:

Thank you so much for the opportunity to share.

Announcer:

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