Death and Bad News Notification

SAEM Ethics Committee
Ethics in the Trenches: A HERO’s GUIDE
Objectives

- Teach a framework for death notification
- Discuss how to deliver news of a serious diagnosis
- Discuss the challenges associated with delivering bad news
Questions?

- Should notification take place on the phone?
- Is it more dangerous to tell or not to tell a family while on the way to the hospital?
- What is the role for therapeutic privilege when delivering bad news?
- Definition of death - Circulatory/Respiratory vs. Brain
- Medical procedures on the newly dead?
- Should family be present for resuscitations?
Ethical Agreement

- Deaths in the ED are frequently unexpected, often traumatic and more commonly involve young people
- Inadequate physician education makes death notification in these circumstances stressful
- As a result of education physicians are often afraid to project helplessness
Educational Techniques

- Several techniques
  - GRIEV_ING Notification Protocol
  - Sequential Notification Technique
  - “Breaking Bad News” course designed by Robert Buckman and Yvonne Kason from University of Toronto
Survey shows 70% of ED physicians find death notification emotionally difficult the majority of the time.

Lack of pre-existing relationship makes situation more difficult.

Fears:
- Fear of being blamed for the death
- Fear of dealing with the family’s emotions
- Own personal fear of death
Death Notification Education

- Only 1/3 of ED physicians have training concerning this in their residency
- ½ have training in medical school
- 94% feel a need for improved training
Key Elements of Death Notification

- Time announcement of death
- Control of the physical environment
- Details of efforts to save life
- Clinical explanation of cause of death
- Staff to help with crisis and grief management
Barriers in the ED

- Physician may be busy with other patients resulting in prolonged waits
- No suitable private place
- No clergy or support staff available
- ED staff can be desensitized- 25% of families in one survey found the staff to be unsympathetic and not reassuring
GRIEV_ING
G-Gather

- Gather all family members
- Ensure that all members are present
- Optimize the physical environment
  - Quiet and private area
  - Make eye contact
  - Sit at their level
R- Resources

- Call for available support resources
- Chaplain
- Family
- Friends
- Social Workers
I- Identify

- Yourself
- Name of patient- Always address patient first as they should be the focus
- State family’s knowledge of the crisis
E- Educate

- Tell about events in ED and current state of patient
- Only give information the family is prepared emotionally for
V- Verify

- Verify that family member has died
- Use the word “dead” or “died”
_ (SPACE)

- Give space and time to absorb
I- Inquire

- Ask if there are any questions and answer them
N- Nuts and Bolts

- Organ donation
- Funeral
- Personal belongings
- Allow viewing of body
  - Inform about presence of lines, tubes, color, temperature changes
  - Should be accompanied
  - Viewing often helps with acceptance of death

- Be familiar with coroner's laws
  - Autopsy required if death from violence, death within 24 hours of general anesthesia, death in prison, death involving public health hazard
G- Give card

- Provide family with name and number of staff person who can answer any other questions that may arise
Challenges & Approaches

- Ignorance of pre-existing family problems hinders the process
- Brain Death
- Drug Abuse
- Grief
- Homicide
- Violent Reactions
- Who should deliver news?
Who should deliver news

- Physician- Surveys show this is family preference due to authority
- Nurse- Some prefer due to statement of more compassion
- Social worker, Chaplain, Counselor- Some prefer this because they are more calm- (i.e. Did not just run a code)
- PMD- Can provide staging
Organ Donation

- Harvesting in the ED is very rare
- Ischemia resistant tissues such as cornea, bone, skin, tendons, fascia, cartilage, veins and heart valves can be harvested up to 24 hours after death
- Patient will not be considered if died from infectious disease, cancer or toxic substance exposures
Procedures on the newly dead

- In a survey of hospital EDs 54% practiced intubation on recently deceased and only 3% of the time were families informed.
- Survey shows about 2/3 of residency programs allow procedures to be performed on the newly dead.
- Often invasive procedures are performed at the end of the resuscitation attempt delaying the pronouncement of death.
Drug abuse

- Family may be unaware
- May be enablers- Guilt
Homicide

- Sense of loss and helplessness
- Shame
- Loved ones may have many questions
Grief

- Kubler-Ross Stages
  - Denial
  - Anger
  - Bargaining
  - Depression
  - Acceptance
Autopsy

- Rates of autopsy have declined
- Benefits
  - Clarify a diagnosis
  - Pose a research question
  - Legal explanation for unnatural deaths
  - Increased accuracy of vital statistics
  - Identification of contagious or genetically linked diseases can benefit families
Telephone Notification

- Identify with whom you are speaking
- Introduce yourself
- Speak slowly and allow the person time to adjust—especially if in the middle of the night
- Let them know you would rather be speaking to them in person
- Precede the news with warning statement. Such as “I’m afraid I have bad news about _____”
- If interrupted and asked if the patient has died say “I’m sorry to say that ____ has died”
- Find out who is with the relative or who is available to provide support and suggest they contact them
- Offer further contact such as being available at the hospital
Delivering Serious News
Delivering Bad News of a Serious Diagnosis

- Buckman’s Six Step Method
  1. Get off to good start
  2. Find out how much they know
  3. Find out how much they want to know
  4. Share information
  5. Respond to patient’s feelings
  6. Planning and follow-through
Step 1: Get off to a good start

- Optimize physical environment
- Make eye-to-eye contact
- Sit at patient’s level
- Ask patient who they want there and who they prefer is not there
- Make introductions
- Shake hands or touch patient if receptive to physical touch
- Always address the patient first
Step 2: Find out how much patient knows

- Use open ended questions
- Example: “what can you tell me of your understanding of your medical problem?”
Step 3: Find out how much patient wants to know

- This may be affected by culture
- Ask things such as “If this condition is serious, are you the kind of person who likes to know exactly what’s going on?”
- Ask if there is somebody else they would like for you to talk to?
Step 4: Share information

- Share according to what patient needs and desires
- Decide on diagnosis/treatment plan/prognosis/support
- Remember what is important to the patient
- Give information in small chunks
- Use plain English
- Reinforce and clarify frequently
- Listen to what is important to the patient
Step 5: Respond to patient’s feelings

- Identify and acknowledge bad feelings
- Do not ignore anger, despair, and hostility
Step 6: Planning and Follow-through

- Discuss advance directive, aggressive therapy, quality of life
- Establish follow up and plan of care
- Remember that a competent adult can accept or reject any suggested care
Policy Implications

- Residents and physicians desire further training in ED death notification
- Having a written protocol for death notification and practicing with role playing makes the situation less stressful for all
References

- Fletcher’s Introduction to Clinical Ethics. 3rd Edition. Fletcher, Spencer and Lombardo. 2005