

Delivering the Bad News:  
Dealing with Death and Difficult  
Issues in the Clinical Arena

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■ *Ideally, every human being ought to live each passing moment of his life as if the next moment were going to be his last. He ought to be able to live in the constant expectation of immediate death and to live like this, not morbidly, but serenely.*

■ *Arnold Toynbee, English historian*

# Bad News

## ■ Defined as:

- · Any news the recipient does not want to hear
- · Any situation fostering a sense of hopelessness
- · An event that promotes an undesired change in lifestyle
- · News resulting in a change in the person's physical or emotional health
- · News that will limit patient choices in life or death.

# The Normal Grieving Process

- Grieving allows family members to come to terms with the death of a loved one. It is a multi-step process that ends when the family member reconciles the death and moves forward with a newly defined way of life. On average, the process takes six to ten weeks, although it may last up to a year.

# The Normal Grieving Process

- Kubler-Ross - Described a 5-stage process of grieving. Her model addresses grief in terminal illness, where death is protracted. "DABDA"
  - . Denial
  - . Anger
  - . Bargaining
  - . Depression
  - . Acceptance

# The Normal Grieving Process

- Epperson - Devised an updated model for *acute* grief reactions, specifically addressing sudden death.
  - • *High anxiety* - Physical symptoms include agitation, tachycardia, tachypnea, nausea, diarrhea, and presyncope.
  - • *Denial* - Emotionally protective phase to allow psyche to catch up with events.
  - • *Anger* - Can be directed at self, family member, deceased, health care workers.
  - • *Remorse* - Guilt and sorrow. Feelings of inadequacy for not preventing tragedy.
  - • *Grief* - An overwhelming sadness that stands in the way of daily life.
  - • *Reconciliation* - The endpoint to the acute grief reaction. This marks the beginning of the acceptance phase.

# Delivering the Bad News

- *Get It Right The First Time:*
  - Introduce yourself
  - Identify all participants
  - Assess relationships with patient
  - Identify level of understanding
  - Now begin.....

# Delivering the Bad News

- The doctor must deliver the news. This task cannot be delegated; otherwise the family will think that their loved one did not receive the highest level of care.
- A support person who can remain longer than the doctor should be present and serve as the contact. This can be a member of the clergy, a social worker, or a nurse. If you must leave the room, this person can remain to provide continuity of care.
- The tone set by the bearer of bad news has a significant impact on the grief response.
- Those in teaching hospitals should mentor a medical student or resident by taking them to observe. Most doctors have learned by trial and error as most training programs don't address this issue.

# *What?*

- This is a necessary part of your job that you must do as competently as any procedure.
- Review hospital protocols that may vary for end of life issues.
- Emotionally prepare yourself for this task. You must shift gears from a medical expert to an emotional support person. In your usual role you can rely on protocols, objectivity, and mechanical skills. This role requires interactive skills and empathy.
- View yourself as calm. Slow down and plan to speak in a deliberate manner.
- Be prepared about what you want to say. Review the events before meeting with the family. Learn the name of the deceased.
- Forgive yourself for your inability to be super-human.
- You have to give them unexpected news that is made more difficult because you may not have an established relationship with the family.

# *When?*

## ■ In person

- Initiate contact upon the family member's arrival in the patient care area. Don't make them wait too long once they're in the room.
- If the resuscitation is ongoing, a student, intern, nurse, social worker can go in and establish rapport and set the stage for the serious nature of the events. They can ascertain the medical history.
- Some literature supports the presence of family members in the resuscitation area. Physician comfort with this idea is variable. In a study of British registrars, those with the least training said they would object to this practice while the most senior consultants were neutral or positive about the practice. It is best studied and accepted in the pediatric setting.

# When?

## ■ By telephone

- If possible, avoid giving bad news over the phone, especially if it is unexpected.
- Remain calm during the phone encounter and attempt to convey concern and warmth during the interaction.
- Identify yourself, the hospital and your role in the patient's care. Be sensitive to time differences.
- Clarify the identity and relationship of the person answering the phone.
- State the name of the person you are calling about.
- Try to contact family while the patient is still alive so you won't be tempted to misrepresent facts.

# When?

## ■ By telephone

- Gently inform the family member that the patient was injured and the situation is critical.
- Find out if there is someone else in the house with them to drive them to the hospital and lend support.
- Widows are especially susceptible to suicide following the news if left alone.
- It is acceptable to notify the next of kin by telephone if they live a great distance from your hospital.

# *Where?*

- The notification should take place in a comfortable, private location that is of adequate size.
- Public areas such as the waiting room or hallways are not acceptable.
- Have personal amenities available - e.g. tissues, water, telephone
- No interruptions. Turn beepers off.

# Why?

- If bad news is delivered poorly, there will be no chance to make amends. *Lack of communication is the most common cause of litigation.*
- This allows family members to initiate the grieving process.
- The family will associate your delivery of the news with the hospital and the care delivery forever.

# How?

- Make assurances that all members of the health care team are on the same page prior to discussions with the family/patient.
- Wear a clean white coat that is free of bloodstains, especially in a traumatic death.
- Enter the room and introduce yourself pleasantly and learn everyone's identity. Try to address the next of kin, not necessarily the person who seems to be paying the most attention. Give the *immediate* family the opportunity to receive the news in private if requested.
- Sit down to imply that you have unlimited time.
- Evaluate social supports available to the patient and family, including religious and spiritual leaders.

# *How?*

- Be sensitive to the family/patient's culture, race, religious beliefs, and social background.
- For Pediatric cases tell both parents together so one does not have to be the bearer of bad news for the other.
- Position yourself closest to the door in case there is an angry or armed family member.
- In cases of violent death the presence of security should be obvious to all involved.
- Be conscious of your body language. It may send a louder message than your words. Sit down, maintain eye contact, lean forward, and nod in agreement-actively listen.
- Ask them what they know about the patient's condition. Always address the patient by name. Ask them to tell you what happened to the patient.

# *How?*

- A warning line may be helpful, "I'm afraid I have some bad news..."
- The family won't hear anything you say after the word "died."
- If you need any information, ask before you tell them the news.
- Deliver the news at the receiver's pace in terminology that is appropriate for them. This increases their sense of control and comprehension.
- Utilize charts and diagrams to paint a picture. Utilize statistics and evidence based outcomes when applicable.
- Eye contact, limited touching, and offering a tissue or drink of water may be helpful.
- Summarize the events, in chronological order, starting with what they know from home.

# *How?*

- Reinforce that they did everything possible and properly.
- Tell how the paramedics brought him in and shocked him, gave drugs, immobilized him.
  - Tell how much of an effort your team made - ACLS measures, surgical procedures, etc.
- "Despite the best efforts of the paramedics, nurses, doctors, and modern technology, I'm sorry, but your husband died."
- Add that the person did not suffer throughout the resuscitation process.

# How?

- Don't use euphemisms!
  - ("Your husband has... passed away, gone to the great beyond, passed on, didn't make it...")
  - It is important to use the word "**died.**"
    - Try to use the active voice "your husband has died..." rather than the passive voice, "your husband is dead."
- In general, it is not overly helpful for bearer of bad news to cry with the family.
  - They expect you to be organized, compassionate and supportive. If you are very attached to the patient and family, this may be unavoidable and in some instances offers closure for you and the family.

# *How?*

- Do not say, "I know how you feel."
  - They may ask you how you coped with your similar tragedy. Also, this shifts the attention to the care giver and not the family/patient. Instead, offer condolences and tell them you are sorry for their pain and realize that they are grieved.
- Avoid insensitive remarks, such as:
  - "You're young, you can have another child."
  - "You should be thankful that you already have two healthy children."
  - "Your mother is better off now, anyhow."

# *How?*

- Ask the family members if they have any questions. Offer support by staying with them a few minutes. Tell them how they can reach you if they think of questions at a later time.
- Inform them that they can view their loved one and then have someone accompany them to visit.
- Acknowledge your own shortcomings and emotional difficulties in breaking bad news.
- Document well within the medical record those discussions with the patient/family and decisions made.
- Consider sending the family a summary document of events or schedule a follow up consultation.

# Dealing with the Reactions of the Family

- Be prepared for spontaneity
- Most emotionally charged events in our lives have a prodrome, but this is often not the case in these instances.
- Allow for anger and mistrust-these are normal reactions and should not be taken personally.
- The way a family reacts to the news depends on their emotional stability, cultural expectations, prior experience, and their relationship to the deceased. You can't make the family feel better, but you can show a caring attitude.
- Let the family speak, then show them you've heard what they've said. Encourage them to share memories of the deceased with you or a member of your team. Be a good listener and a caring human being.

# Dealing with the Reactions of the Family

- Don't get into an argument with the family. Involve security early.
- Avoid squelching normal grief reactions - tranquilizers just postpone the initiation of the grieving process. However, if an emergent medical reaction occurs, the family member may need to become a patient."
- Pediatric deaths are even more difficult. Parents always feel responsible for their child's death. Even if a family member is responsible for death, it is helpful to point out that they did not intend harm. It is important to allow parents to spend time with their deceased child. Encourage them to hold the child. They may feel worried to leave the child in the room alone and unprotected. Reassure them that you will take care of their child.

# Legal and Logistic Arrangements

- Call the deceased by name, not "the body."
- Offer each family member the opportunity to view the body - this gives closure. Warn them of the presence of tubes, disfigurements. Clean the patient, dress the wounds, clean up the blood on the patient and the floor. Close the patient's eyes, place the head on a pillow, and leave the hands accessible, especially wedding rings, jewelry. Do not place them into a body bag under the sheet.
- Offer to call a member of the clergy - either their own or the hospital cleric on call. Offer social services now, and written instructions for contacting them in the future.
- The family must call the funeral home.

# Legal and Logistic Arrangements

- Coroner's case - mandatory for suspicious or violent causes of death, or in cases where the patient is not under the care of a physician or is recently post-op. The coroner's office decides if they want to do an autopsy. You need to leave the body and resuscitation tubes intact and notify the family that the body will be released to them at the coroner's discretion.
- Autopsy may be offered in case of an unknown death to learn the cause.
- Organ donation may be broached by procurement agencies, but should not be done at the same time of notification of brain death or impending brain death.
- Have written materials available for family to read in the future about grieving, support groups (local, national, or Internet), your hospital's social work number, your name and number for questions.
- Death certificate - must be completed in a timely fashion. The patient's doctor should be notified and may be willing to sign the certificate

# Taking Care of Yourself

- Communicating bad news is stressful for physicians. Typical fears include loss of control, fear of unleashing a reaction, fear of expressing emotion, fear of being blamed, fear of not knowing the answers, fear of illness and death.
- Death telling reminds you of your own mortality. You may imagine the possibility that your loved one may die in the same way. You may relive your experience of learning of your family member's death.
- Take a few moments to acknowledge your feelings and cope with them.

# Taking Care of Yourself

- Call the medical team together for a debriefing session to share feelings. Usually this is done informally as members of the health care team complete paper work and straighten up the resuscitation area. Critical incident debriefing sessions by a professional may be necessary, especially in a gruesome or heart wrenching situation.
- Remember your subsequent patients - they need your undivided attention.
- Professional help - Do not be afraid to seek professional help if necessary.

# Priority Care for the Dying Patient

- Relief of pain and other terminal symptoms
- Maintenance of function and control
- Support of family and personal relationships
- Avoidance of impoverishment
- Trustworthiness and continuity of care
- Attentiveness to meaningful activity
- Spiritual issues
- Never remove **HOPE**

# Checklist of Factors to Review with the Dying Patient and Family

- Assess patient's and family's understanding of current medical status, treatment options, and emotional reactions to this information. Solicit what the patient wanted or would have wanted. Not what family members want for the patient.
- Evaluate social supports available to the patient and the family.
- Determine communication level between the patient, the family, and the staff.
- Do not ask family members to sign a DNR if it is not required by your institution. Document an agreement to a treatment plan within the chart and you, the physician, sign the DNR paperwork

# Checklist of Factors to Review with the Dying Patient and Family

- Assess coping mechanism for the patient and the family.
- If drug/alcohol abuse or psychiatric problems exist, identify short-term support to ensure safety and minimize impact of death on preexisting circumstances.
- Assess surrogate decision maker's understanding of and ability to make decisions regarding forgoing life-sustaining treatment

# Documentation

- Goals of care should be specific in the patient's chart – comfort care measures to assure pain relief and a dignified death.
- Orders for pain medications should be specific and attached to objective physiologic markers: pulse > 20% increase, mean blood pressure > 20% rise, respiratory rate > 24, accessory muscle use, and grimacing or clutching.
- Considerations for organ procurement should be made by an independent organization, not the primary patient care giver.
- Family discussions should be documented within the progress notes with a consensus noted for treatment plans
- At time of death complete the necessary paperwork: death certificate, permission for necropsy, death notification form, death note – see attachments

# Conclusions

- Delivering bad news is an important part of a physician's job.
- The manner in which the news is delivered to family members will have a long lasting effect.
- Proper training and experience will facilitate the process.
- **Remember to treat your patients as you would like to be treated.**