Developing communication skills in medicine

Telling relatives that a family member has died suddenly

Jonathan Marrow

Summary

Persons dying suddenly are very likely to be taken to the nearest Accident and Emergency Department. The task of informing and counselling bereaved relatives therefore frequently falls to the staff of these Departments. Adequate preparation is important in allowing such situations to be dealt with in a sensitive and appropriate manner. Advice on coping with different aspects of sudden death is given and some common reactions discussed. Special problems are also considered (eg, the death of a child, criminal violence, communication difficulties). Aftercare must also not be forgotten and staff should receive training in the care of the bereaved.

Keywords: bereavement counselling, communication skills, sudden death

Patients in the UK who die suddenly are very likely to be taken to the nearest hospital Accident and Emergency Department. Death may follow collapse or the deceased may be found apparently lifeless. Severe injuries may prove rapidly fatal.

Major advances have been made in developing sound procedures for resuscitation of those suffering sudden cardiac arrest and also for the efficient management of victims of major life-threatening trauma. Training in these procedures is seen as a high priority for doctors and nurses in many disciplines as well as for paramedic ambulance staff and other emergency personnel.

Application of the principles of Advanced Cardiac Life Support, Advanced Trauma Life Support and Paediatric Advanced Life Support should reduce the number of people who are brought in dead to Accident and Emergency Departments and increase the proportion of those arriving in a critical condition who leave the department alive. It is absolutely right that we strive to develop and maintain our practical life-saving skills in these areas but there is another side to the care of the critically ill or injured which deserves more attention.

Practically every time death has to be confirmed in the Accident and Emergency Department, there will be relatives or friends to be found and informed. Death has usually come quite unexpectedly, making the task of sharing the news all the more difficult. The suddenly bereaved effectively become our patients, every bit as deserving of our care as the person who has died.

Apart from fulfilling a clear duty, providing proper care for the recently bereaved has an important role in reducing future psychiatric morbidity.¹ There have been many local initiatives regarding this aspect of care in the Accident and Emergency Department.^{2–5} The Department of Health has issued useful, but rather general, guidelines in its document *People who die in hospital*.⁶ The recent excellent publication, *Bereavement care in A&E departments*,⁷ is greatly to be welcomed but the care of the suddenly bereaved has still, in general, not been given the high national profile allotted to improving our efforts at resuscitation.⁸

We are naturally reluctant to admit the possibility (in some situations, the high probability) that resuscitation will fail. Also, formal teaching of the practical skills of life support seems much more straightforward than that of communication in the tragic crisis. Learning what to say and how to say it is one component. Learning to listen, and to be aware of non-verbal communication, is just as important and for many it is even harder to learn.⁹

Sharing feelings beyond your personal experience

Most healthcare professionals will have to make use of imagination to begin to grasp the feelings of the person who has suffered sudden personal loss. The ability mentally to place yourself in the position of another individual is hard to teach but can greatly improve the care given to a person who has to hear news of sudden bereavement.

There must, for example, inevitably be a great gulf in life-experience separating any working doctor or nurse and a newly widowed 85-year-old whose husband or wife has just died after 60 years of marriage. The only way this can be bridged is by imagination, together with a habit of study of other individuals. The opportunity for such study is one of the great privileges of medical and nursing practice. It demands continuing awareness of the feelings and pain of patients in all sorts of clinical situations.

While the task of initial care for those suddenly bereaved often falls on Accident and Emergency Department staff in the UK today, it is by no means our monopoly. The skills involved need to be as widespread as those of the various forms of life support.

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Before you talk to bereaved relatives

- ensure privacy; seek a non-clinical, comfortable environment
- try to make time, so that you are not rushed or disturbed
- make sure that you will not leave the bereaved person alone after the interview and that some support is available (eg, a nurse or other healthcare professional, relatives or friends, appropriate religious support)
- check your facts: Identification of deceased. Is there any doubt who has died? Identification of relatives. Who are you going to talk to? What has the relative already been told? Will you be able to answer likely questions about patients?
- check your appearance: take off blood stained gloves, gown etc.

Accommodation in the A&E Department

- room for distressed relatives: private, quiet, in or near A&E Department, with a telephone and access to washroom and toilet
- room for viewing body: private, with “In use” indicator panel on door, suitable decor, non-denominational, close to A&E Department, without obstructing care of new patients, accessible without long delay, relatives need to be able to touch and hold, not just view through window

Seeing the person who has died

- opinions differ about relatives being present during resuscitation (widely accepted with children)
- opportunity should always be offered to see body as soon as possible after death
- should be encouraged but never forced
- clear explanations of visible injuries or therapeutic interventions will be needed
- allow relatives to touch and hold their loved one
- allow a lock of hair to be cut, if it is requested
- be ready to support bereaved relatives but also to give them privacy with deceased (if legal situation allows)
- time with deceased should be as unrushed as possible
- Polaroid photography should be offered, and retained if not wanted at time

Relatives must have news, even when it is bad

Relatives often arrive when colleagues are still trying to resuscitate a patient who has suddenly collapsed, or been brought by ambulance from the scene of an accident. They deserve information and should be kept informed as quickly as possible. The uncertainty of waiting for news of someone you love is in many ways more painful than knowing what is happening, even if the news is bad. The desperate anxiety which families experience makes time seem to stop moving, so that minutes drag like long hours. The hectic activity of the resuscitation has the reverse effect on the time perception of staff involved.

Preparing for the interview

The need to tell the relatives what is happening is pressing, but there is still time to pause and check you have the essential facts. Make sure you know the name of the patient you are talking about. Be aware if there is any doubt about their identity. Have some detail of the patient’s build and clothing in your mind to help make sure. Check that you have the latest facts about the patient’s condition. Try to find out to whom you are going to speak.

WHERE TO TALK WITH BEREAVED RELATIVES

Every Accident and Emergency Department should have a room which can be set aside for the exclusive use of the family of a seriously ill patient, or one who has recently died.^{2,4,5} The room should be comfortably furnished and decorated in a domestic rather than a clinical way. It needs to be sufficiently close to the resuscitation area for the family not to feel they are being separated excessively from their loved one. It should be secluded from public gaze. The room may sometimes be used for interviewing other relatives or for other occasional uses, but it must be tidy and available for immediate use at any time. It is really not appropriate for a registrar’s office or a staff rest room to double as a room for bereaved relatives.

THE BEREAVED RELATIVE AS YOUR PATIENT

People’s reactions vary a lot. You are unlikely to have met the family before but suddenly you are going to shake their world. You will leave impressions they are unlikely ever to forget. Up to now, your skills will mainly have focused on your patient who is dying, or has died. You need consciously to turn your attention onto the person you are going to meet, regarding them now as a patient in need of your care in their own right. Some departments now follow the practice of registering the bereaved relative as a patient, which can be a helpful reminder of this need.

A NURSE TO SUPPORT THE BEREAVED FAMILY

I always try to take someone with me, preferably an experienced nurse. Someone needs to stay with people who have just received bad news about a person close to them, to listen to their further questions, to comfort and support them. This is particularly important when the bereaved person is alone, of course. The ideal is that one person, usually an experienced nurse, can be freed of other duties so that he or she can act as the named nurse, allocated to stay with the bereaved family, supporting them and, where necessary, acting as an advocate for their interests.

HONESTY WHEN THE OUTLOOK IS POOR

My title refers to breaking news only of sudden death, but often there is a preliminary stage, when the patient is clearly desperately ill and news has to be given to a relative who has come to the hospital. Honesty has to be the key. If you do not know what is wrong, it is best to say so, explaining that every effort is being made to find out the diagnosis. It is important to make sure that the family do realise when the outlook is very poor. They will very much want to be told, after all, that things are not as bad as they at first seemed. It is sometimes necessary gently but clearly to repeat statements in this situation.

GIVING RELATIVES ACCESS TO THE DEAD OR DYING

It is very important to be with a close family member, able to see them and hold them, when they are ill or injured. Families who have not been allowed to be with someone who has died suddenly can feel as if they have let their loved one down by not being there before he or she died.¹⁰

Some suggest that the best way for the close kin of a gravely ill patient to appreciate what is happening, and to realise how hard staff are striving to keep them going, is for the relative to be with them, even in the hospital resuscitation

room.¹¹ There is a tradition among staff that relatives will be too upset by medical procedures during resuscitation (and may get in the way). There is also probably a self-consciousness about carrying out emergency procedures with ‘an audience’. From departments where it is routine practice, I understand that relatives in the resuscitation room do not cause as much stress for staff as might be expected.

The implications of inviting relatives into the resuscitation area do need to be carefully thought through. Different groups of medical and nursing staff need to be consulted and careful arrangements made. It is already the usual practice in some hospitals to invite relatives to visit the resuscitation room while resuscitation is in progress. Some allow it occasionally. Not all relatives accept, and there should certainly be no coercion. The practice is particularly favoured in paediatric Accident and Emergency Departments. The named nurse responsible for the family should stay with the relatives in the resuscitation room, ready to offer explanation and support and also to judge if it is time to return to the relatives’ sitting room.

The interview

Being at the hospital, even for a short time, before the close relative has died, can seem to make adjustment to sudden bereavement a little easier, even following a sudden accident or illness. It used to be a common practice that the family would first be told that the patient was desperately ill, even when they were actually dead already. They would later be told that resuscitation had been to no avail. It was done with the best of motives, to try to ease the blow of sudden bereavement, but I would advocate a more honest policy. Untruths are revealed, for example, when a family member is on the hospital staff or when a relative realises that death was actually confirmed before the first telephone call summoning the family to hospital was received. It is important that the bereaved family can carry on, adjusting sadly to their loss but confident that they have been in touch with developments throughout. An open, honest approach will maintain trust, even if at first it seems unkind.

THE INTERVIEW AS A CONSULTATION

Superficially, the interview to break the news of sudden death may appear simply to be a meeting where the doctor or nurse gives information to family members, a one-way process. I suggest that it should better be approached as a consultation with a new patient. You do have information which has to be given, but you will do the job much better if you are prepared for an exchange. You need to be alert for signs from the relative or family group. Early on you will gain information about their current understanding and attitudes, which may guide you as to how best explain what has happened. Later, when they know of their loss, the reactions and questions of the bereaved family will indicate what further facts you need to tell them, or find out, and also what further support may be needed.

You need to say who you are and establish with whom you are speaking. Try to put yourself on a level with your new patient, physically as well as in human terms. Sit with them, rather than standing over them. They may already have a very good idea what has happened. Try to sound out what they know about the sudden illness or accident but do not go on too long before sharing the bad news you have come to tell. Your manner needs to be appropriate to the situation. The way you choose to describe what has happened needs to be gauged according to the person you are talking to, their age and probable understanding of medical language. There are many euphemisms surrounding the end of life. Most are used to avoid the discomfort of recognising the speaker’s own mortality. They may be open to misunderstanding and are usually better avoided.

REACTIONS TO BAD NEWS

People’s reactions in the situation of sudden bereavement vary enormously. Tears, questions, anger, doubt and guilt are just some of the facets. Some people will be so calm and quiet that you are unsure if you have expressed yourself clearly. Others will quietly thank you and offer sympathetic support to you, conscious of how difficult the task of breaking the bad news must be.

The work of doctors and nurses is often seen to require a degree of detachment from violent emotions. Too close involvement can, indeed, sometimes make it difficult to reach rational decisions about patient care. Recognising your own distress when a patient has died shortly after admission to hospital, for example, can make you better able to appreciate the level of the grief of those more personally involved.

With the bereaved relatives

- build a bridge: introduce yourself and put yourself on a level with them physically
- establish relative’s current information: What happened before sudden illness or accident? What do they know about the sudden illness/accident?
- be alert to verbal and non-verbal signs from relative: be ready to confirm direct questions "Is he/she dead?"
- do not prolong the agony of not knowing: if there has been no direct question, be ready to give brief account of injury or illness and, with regret, explain that treatment has not been successful and that relative has died
- use clear language, expressed with sympathy, but usually avoiding euphemisms
- listen – be responsive to the relative’s reaction: follow with a more detailed explanation; go on listening, do not plough on, stifling the relative’s questions and reactions. Many relatives now ask about organs for transplantation. Have initial answers and be ready to make prompt enquiries

Some common reactions

- disbelief: “Are you sure he/she is dead?”, “Could there have been some mistake (of identification)?”
- guilt: “If only I had made him go to the Dr”, “I should have stopped him driving when he was tired”
- anger: against the deceased, against previous medical care, against you, against God
- unusual reactions (occasionally needing psychiatric help): resolute denial, even after seeing the body; violent anger; disclosure of long-standing family strife, suspicions, accusation

Information the bereaved family will need

- procedures about clothing and possessions
- explanations of Coroner’s procedures and registration
- written details about formalities necessary after a death (registration, etc)
- written details of contact they can make for more explanation (with Department)
- facts about transplantation, if requested
- possibilities of medical use for bodies, again, if requested

Afterwards

- bereaved family may need help with transport home
- may need overnight accommodation at hospital
- may need long talk with staff member best known to them (often a nurse who has sat with them while they waited for more news)
- family doctor should be informed by the quickest possible route
- bereaved family may want to ask for more information later
- should have opportunity to talk again with hospital staff, preferably named doctor or nurse, if they request it

Special problems

- sudden death of children: sudden infant death; in an accident; in apparently avoidable circumstances
- death by criminal violence: grief and anger; needs of police; media attention
- the bereaved person is also seriously hurt: they need to be awake enough to understand; consult rest of family but do not delay breaking news too long
- communication difficulties: language; disability; bereaved children
- cultural factors: religious obligations; beliefs and traditions of grieving
- relative on telephone: locally; at long distance, overseas
- media enquiries to you and to the family

THE PLACE OF PHYSICAL CONTACT

Human touch is an important part of communication, particularly in the way we show sympathy or shared emotion. Touching a hand or arm or putting an arm round the shoulders of a person in distress can express our shared feelings far more effectively than words. Each person must find his or her own comfortable level. There is no prescribed correct way. You should not feel that you have to get closer than you feel is comfortable or natural.

HELPING WITH LEGAL FORMALITIES

There are procedural details which families need to know. There are usually legal obligations relating to sudden death (such as reporting the death to the Coroner in England and Wales, or the Procurator Fiscal in Scotland). Registration of death needs to be explained. A *post-mortem* examination may be legally required, which will need great tact if there are cultural or religious objections.¹³ If possible have the facts available. Be ready quickly to find out a detail, if you do not have the information straightaway. The shock of acute grief makes it very difficult to retain information so well laid-out leaflets are very useful. Translations should be available where there is linguistic diversity.

QUESTIONS ABOUT TRANSPLANTATION

Questions about transplantation are often raised. When death has already occurred the possibilities for organ donation are usually limited to use of the corneas, but these alone are very valuable and you should know how to arrange for them to be used if it is possible in your area. Legal formalities (for example, with the Coroner in England and Wales) need to have been agreed beforehand. Knowledge that at least some good has come out of a sudden death can bring great comfort, particularly if the family know it would have been the wish of the person who has died.

CLOTHING AND OTHER PROPERTY

Great distress can be caused by lack of thought about clothing or valuable property after a sudden death. The family will need explanation when clothing has had to be cut off and warning about possible soiling. Clothing may have been retained by police officers, if there is a possibility of violence. The family need to be told this. It can be a kindness to have the clothes quickly washed through but some relatives feel that washing their son’s or husband’s clothes for the last time is at least one thing they can do in a situation where they feel very helpless. Wherever possible, the decision should be theirs.

After-care

Some departments have arrangements for after-care following sudden bereavement. A dial-in telephone number to ring and a named nurse, or doctor, to ask for can be helpful when queries arise after the family have left hospital. Hospital staff will not wish to take over the role of the family doctor, but an opportunity to discuss the *post-mortem* report with a doctor who was involved in the patient’s care at hospital can be helpful. Uncertainties linger terribly, making adjustment to loss especially difficult and prolonged.

SENSITIVITY TO THE NEEDS OF RELIGIOUS GROUPS

Religion and culture play a large part in our attitude and reaction to death. We need to be ready to help with requests relating to religious needs, particularly as many groups feel that it is their duty to carry out rituals correctly at the time of death.¹² It is a unique moment for the one who has died and the family will have failed him or her forever if the chance is missed. There should be hospital chaplains for the main denominations but it is helpful to keep lists of contact names and telephone numbers for priests or equivalent in the area of your hospital. A list of interpreters available in the hospital and in the community is also very useful.

BEREAVEMENT AND CHILDREN

The death of a child is a specially hard loss and caring for the distressed family when a baby has been found to have died suddenly is particularly gruelling.¹⁴ This will be discussed further in a later article in this series.

Helping children who have suffered bereavement is another very difficult area. They may attend with adult relatives but may, occasionally, be the only uninjured survivor in some family tragedy. There is not room in this short article to discuss the issues in any detail. Essentially, children need understandable information and support. They need to be told what has happened. After suitable explanation they should be allowed to see the body of their parent

Headings for a policy on bereavement care in an A&E Department
<ul style="list-style-type: none">• training of staff involved in the care of the bereaved• responsibility for breaking bad news• support for bereaved families in Department (named nurse)• maintenance of room for distressed relatives and viewing room• maintenance of information for staff and for the bereaved, eg, telephone numbers and leaflets• registration of bereaved relatives as patients• protocol about presence of relatives during resuscitation• protocol on viewing of the deceased by relatives• list of agencies to be informed when a death has occurred in the Department• procedures about the property of deceased relatives (including clothing)• support from Department after the initial bereavement (contact name and phone number, home visits, visits to specialist clinic where relevant)• support of staff involved in care of the bereaved

Case study
<p>A young man, recently separated from his wife, attended an A&E Department with back pain. After careful assessment, a simple strain was diagnosed and he was allowed home to rest. He collapsed on his way home and died soon after being brought back to the hospital. Medical and nursing staff were profoundly shocked as there had been no indication that he had been in danger when he first left hospital.</p> <p>The patient had not wanted staff to contact his wife when he first attended. He had not even given her address, because of the separation. Staff did contact the young man's father-in-law by telephone while resuscitation was going on. He was to contact his daughter and she would come to hospital. She in fact phoned first. By now her husband was dead. The sister who spoke to her was herself shaken by the unexpected death. This was obvious in her speech. She felt that she had to tell the caller honestly what had happened. She had no idea of the cause of death.</p> <p>The death was reported to the Coroner and a <i>post-mortem</i> showed a massive pulmonary embolus. The source was not found. The young widow spoke to the coroner's officer on the next day but did not come to hospital. The Coroner accepted that the death had been due to natural causes. The widow did not know where to turn for more information.</p> <p>A week later, at the request of the widow's family doctor, the consultant arranged to meet the widow and she was grateful for a full explanation of what was known about what had happened. She accepted that the death was a completely unexpected tragedy.</p> <p><i>Lessons</i></p> <ul style="list-style-type: none">• no policy can provide for every eventuality.• even experienced professionals give their feelings away, on the telephone as well as face to face.• when staff feel awkward, and perhaps guilty, about a patient's death, an early meeting with relatives is particularly important.• especially when a <i>post-mortem</i> has shown an unusual cause for sudden death, hospital medical staff must take the initiative to talk to the family about it.

who has died, if they wish to. They need to be allowed to react in their own way. Care for them by other relatives or if necessary by official agencies needs to be worked out. The help of the paediatric ward may be enlisted for a bereaved young child, for example, pending the arrival of relatives.

CARE FOR STAFF WORKING WITH SUDDEN BEREAVEMENT

Finally, I mention the needs for hospital staff involved in the care of the suddenly bereaved.^{4,15} They need every help in carrying out this very difficult and gruelling task. They need training and preparation for it and they deserve support to help them with the stress it can induce. While often this can be on an informal basis, there needs to be a support structure for staff which allows access to more formal counselling when required. Staff need to be able to seek this help without feeling that it is an admission of failure.

I am particularly indebted to Dr Ed Glucksman and his colleagues on the working group from the British Association for Accident and Emergency Medicine and the Royal College of Nursing for their most valuable publication *Bereavement care in A&E departments*. This work includes extensive discussion of the issues briefly covered in my paper, together with an extensive list of useful addresses and a full bibliography.

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5 McLauchlan CAJ. Handling distressed relatives and breaking bad news. *BMJ* 1990; 301: 1145-9.

6 Department of Health. *NHS Guidelines - patients who die in hospital HSG(92)*. London: DOH, 1992.

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10 Renner S. I desperately needed to see my son. *BMJ* 1991; 302: 30-56.

11 Doyle C. Family participation during resuscitation - an option. *Ann Emerg Med* 1985; 10: 7-9.

12 Black J. Broaden your mind about death and bereavement in certain ethnic groups in Britain. *BMJ* 1987; 295: 536-8.

13 Sherwood SJ, Start RD. Asking relatives for permission for a post-mortem examination. *Postgrad Med J* 1995; 71: 269-72.

14 Brown P. Saying goodbye. *Nursing Times* 1993; 89: 26-9.

15 National Association for Staff Support. *A charter for staff support (for staff in Health Care Services)*. London: NASS, 1992.

Appendix: Useful addresses in the UK relating to the care of the bereaved		
British Organ Donor Society, 1 The Rookery, Balsham, Cambridge CB1 6DL Tel: 01223 893636	National Association of Bereavement Services, (publish an extensive directory of relevant services) Tel: 0171 247 4818	Sudden Death Support Association, Chapel Green House, Chapel Green, Wokingham RG40 3ER Tel: 01734 790790 (a 24 h helpline staffed by people who have experienced sudden bereavement)
The Compassionate Friends, (offer support for bereaved parents, especially) 6 Denmark Street, Bristol BS1 5DQ Tel: 0117 291778	National Association of Funeral Directors, 618 Warwick Road, Solihull B91 1AA Tel: 0121 711 1343	Victim Support, Cranmer House, 39 Brixton Road, London SW9 5DZ Tel: 0171 735 9166
CRUSE - Bereavement Care, CRUSE House, 126 Sheen Road, Richmond TW9 1UR Tel: 0181 940 4818	The Samaritans, 10 The Grove, Slough SL1 1QP Tel: 01753 532713 (or local telephone directory)	
A more full list is contained in the publication <i>Bereavement care in A&E departments</i>		

Medical Anniversary
CAMILLO GOLGI, 7 JULY 1844

Camillo Golgi (1844–1926) was born in the Alpine village of Conteno in Italy, son of a general practitioner. He studied medicine in Pavia, qualifying (1865) with a thesis on mental disease. He practised as a country pathologist but returned to Pavia as professor of histology (1875). Golgi described the perivascular spaces of the brain and the endothelial origin of psammomas. He introduced a silver chromate stain for nerve cells, distinguishing motor from sensory cells, and he first described the intracellular organelles now known as the Golgi apparatus (1858). He shared the Nobel Prize with Cajal (1906). — *DG James*