Original Research Paper Medicine

Breaking bad news in the Emergency Department: Unexpected events, Unexpected Consequences

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ABSTRACT

Aims and objective: To spread the awareness among physicians that how to deliver the bad news to the relative and to aware the effects of the bad news on the receiving end and to tackle a varied range of emotional outbursts. Breaking bad news training to the physicians can reduce the adverse effect on the receiving end.

Methods: We conducted a randomised double blind study to identify the reaction of the patient's relative while breaking the bad news. In this study, 60 deaths of any age group occurred in the Emergency Department of MGM Medical College, Navi Mumbai from the period January 2015 to September 2015 were taken. Alternate deaths were divided into two groups .Group B was conveyed the bad news in a conventional way and unstructured way whereas a structured format was followed for the Group A.

Results: It was observed that group A was far better able to cope up with the bad news than group B. Initial shock reaction or vasovagal syncope situation was around 20 % in group B whereas in group A it was nearly 6%.Anger situation was found to be around 16% in group B and in group A it was approx. 3%. Psychosis was around 10 %, Guilty around 3 percent and other reaction like denial 3% was found in group B which was relatively higher than group A.

KEYWORDS Breaking bad news, relative reaction, awareness

Introduction

Breaking bad news in the emergency department is very common. Sudden or unexpected deaths happen frequently in the ED. In 2005, there were 287,000 ED deaths in USA.[1]. This is especially true for an emergency physician (EP) as there is little time to prepare for the event and likely little or no knowledge of the patients or family background information. [2]

All bad news, therefore, has serious adverse consequences for patients and families.[3,4] Breaking bad news(death) in the Emergency department is different than routine as the death is sudden and unexpected, allowing very little time for the Emergency physicians to bond with the family leading to outrage of emotions with the unexpected consequences like vasovagal syncope, anger, guilt, psychosis and other emotional outbursts. The doctors depend on their own experience rather than any training received in the medical school.[5]

Informing the family members about the sudden death of their loved one is a highly stressful experience for the treating doctors. In fact, one practical definition of bad news is "any news that adversely and seriously affects an individual's view of his or her future."[6]

The delivery of bad news can have a negative impact on the patient's relative and family friends. While declaring death in the emergency department the family members have often reported feelings of 'guilt', 'helplessness' and wanting to 'take the pain themselves'. Feelings of disbelief, despair, depression, acceptance and denial are so on. The weak area in the process of delivering the bad news is the reaction of the patient's relative, imparting the information pace and providing the written materials to the patient's relative.

Rabow and McPhee developed a practical and comprehensive model, synthesised from multiple sources, that uses the simple mnemonic ABCDE.[7] . Physicians can do advance preparation, build a relationship, communicate well, deal with family or relative reaction, encourage and validate emotions.

It is important for healthcare professionals to recognise that when they deliver 'bad news', whatever that may be, they need to consider how this news can impact on the friends and the family unit.

Aims & Objectives

To spread the awareness among physicians that how to deliver the bad news to the relative

To Aware the effects of the bad news on the receiving end and to tackle varied range of emotional outbursts.

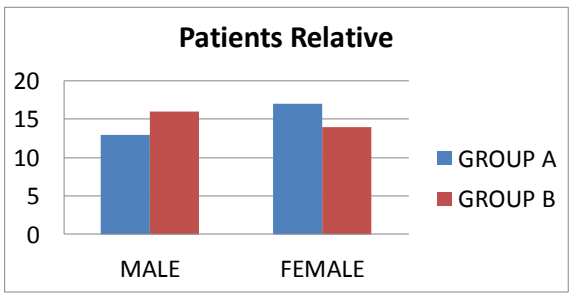
Breaking bad news training to the physicians can reduce the adverse effect on the receiving end.

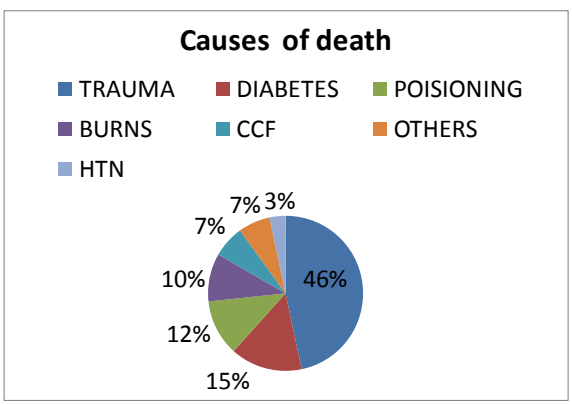
Materials and Methods

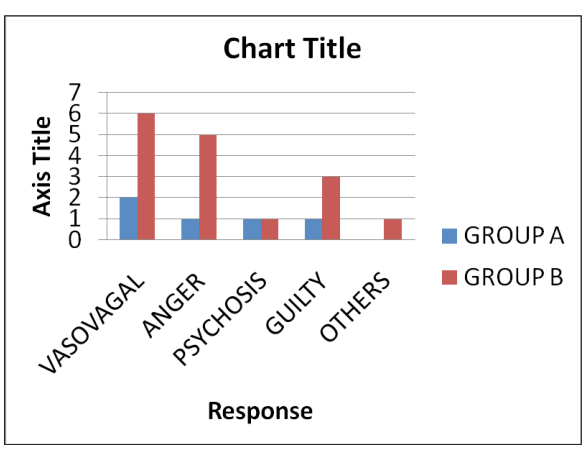
Study design and patient population

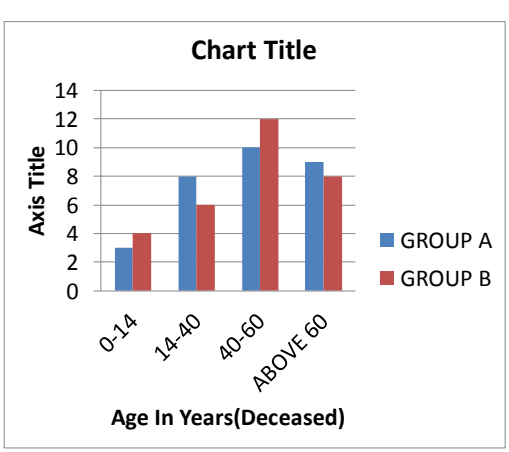
We conducted a randomised double blind study to identify the reaction of the patient's relative while breaking the bad news. In this study, 60 deaths of any age group occurred in the Emergency Department of MGM Medical College, Navi Mumbai from the period January 2015 to September 2015 were taken. Alternate deaths were divided into two groups .Group B was conveyed the bad news in a conventional way and unstructured way whereas a structured format was followed for the Group A. In a structured way, we included the things in the format like: Clearly introduced herself/himself,

clearly stated his/her role in the care of the patients, perception, determined the level of knowledge, inform the patient's relative, briefly indicated the chronology of events leading up to death of the patients, used appropriate language, avoided showing any physician guilt for the loss poor prognosis and showing empathy to the patients relative. The structured format in this research is simply the tips to the clinicians and not to be considered as any form of protocol.









Results

There are 43.33 % male and 56.66% female in Group A whereas in Group B, 53.33% of male and 46.66 % female. In this study, most common cause of the death is trauma around 46 % either in the form of road traffic accident, history of assault or history of fall. In addition to that, the other cause of death by diabetes is 15%, poisonings are 12% and 10 % burns are also on the higher side. It was observed that group A was far better able to cope up with the bad news than group B. Initial shock reaction or vasovagal syncope situation was around 20 % in group B whereas in group A it was nearly 6%.Anger situation was found to be around 16% in group B and in group A it was approx 3%. Psychosis was around 10 %, Guilty around 3 percent and other reaction like denial 3% was found in group B which was relatively higher than group A.

DISCUSSION

Communication and support for the families and friends are of central concern in the health care, and yet too often are poorly addressed; especially in the Emergency department due to poor communication and fatigued staff. A bad news is always a bad news, however well it is said but the manner in which it is conveyed can have a profound effect on both the recipient (the patient's relative) and the giver (the physician).[8] An empathetic approach not only eases the process for the family and friends but also allows the Emergency physicians to strike a healthy communication with the family regarding the patient or the family's' last wishes, organ or body donation or autopsy.

The SPIKES protocol was developed in 2000 by an oncologist to train providers in delivering bad news. [9.] In 2005, the GRIEV_ING educational intervention was developed and tried by emergency physicians.[10, 11] The results of this study revealed a significant increase in confidence, and competence scores in residents' skill of death notification from pre- to post-intervention assessments.[2]

Recommendations

Confirm their identity and relation to the patient.

Closed discussion room

Use simple language

Foreshadow the bad news "I am sorry, I have bad news"

Explain the relative about the earlier condition, and a possible reason for sudden deterioration.

Encourage family members to ask any question or express feelings

The telephone should be provided to the relative so they can communicate.

Do not argue with a relative if they blame or comment on health care team.

If there is the medico-legal implication, where an autopsy is needed to find out the cause of death, the relative should be informed in advance.

Before allowing the relative to view the body, make it more presentable; disconnect all life support like endotracheal tube etc.

Never break the news on telephone

Conclusion

Thus, all the possible measures should be taken to help the distressed relatives to accept the death with relative equanimity .More humane approach from medical staff towards the bereaved family not only benefits the relatives of the deceased but also protects the hospital from potential conflicts sur-

rounding the death of the patient. Unfortunately, most of the emergency physicians have little or no formal training for this task. Hence, the inclusion of this subject in the undergraduate medical curriculum has to be considered. We felt that there should be teaching these communication skills to the emergency medicine residents and it should be an important part of the educational program too.

In this Research, an effort has been made to highlight the importance of formal training of all the clinicians in the art of breaking the bad news to bereaved family and to avoid possible communication pitfalls. The structured formats in this research are simply some suggestions to the clinicians and not to be considered as any form of protocols.

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