JOURNAL OF PALLIATIVE MEDICINE
Volume 20, Number 6, 2017

DOI: 10.1089/jpm.2016.0481

Death Notification: Someone Needs To Call the Family

Rachel Ombres, MD,[1] Lauren Montemorano, BS,[2] and Daniel Becker, MD[3]

Abstract

Background: The death notification process can affect family grief and bereavement. It can also affect the well-being of involved physicians. There is no standardized process for making death notification phone calls. We assumed that residents are likely to be unprepared before and troubled after.
Objective: We investigated current death notification practices to develop an evidence-based template for standardizing this process.
Design: We used results of a literature review and open-ended interviews with faculty, residents, and widows to develop a survey regarding resident training and experience in death notification by phone.
Setting/Subjects: We invited all internal medicine (IM) residents at our institution to complete the survey.
Measurements: Sixty-seven of 93 IM residents (72%) responded to the survey. Eighty-seven percent of responders reported involvement in a death that required notification by phone.
Results: Eighty percent of residents felt inadequately trained for this task. Over 25% reported that calls went poorly. Attendings were involved in 17% of cases. Primary care physicians were not involved. Nurses and chaplains were not involved. Respondents never delayed notification of death until family arrived at the hospital. There was no consistent approach to rehearsing or making the call, advising families about safe travel to the hospital, greeting families upon arrival, or following up with expressions of condolence.
Conclusions: Poor communication skills during death notification may contribute to complicated grief for surviving relatives and stress among physicians. This study is the first to describe current practices of death notification by IM residents. More training is needed and could be combined with training in disclosure of medical error.

Keywords: bereavement; provider self-care

Background

''You sit down to dinner and life as you know it ends.''
—Joan Didion, *The Year of Magical Thinking*

In her book *The Year of Magical Thinking*, Joan Didion recounts her experiences following the sudden death of her husband, the writer John Dunne.[1] Although vividly depicted and deeply felt, her experience is not unique. It might happen to anyone: you sit down to dinner and the phone rings to deliver a message that something terrible has happened to someone you love. Maybe the news was expected, maybe not. Even if the death was expected, the news still shocks and feels unthinkable.[2–4] Or maybe you work in the hospital and it is your job to make that call, to interrupt a dinner and deliver bad news. Families remember not only what is said but also how it is said.[3,5,6] If poorly done, this conversation can prolong and intensify grief. Complicated grief is associated with poor health outcomes for surviving family members, including increased psychological illness, physical symptoms, and increased mortality.[7–10]

Clinicians may also experience grief after a patient's death.[11,12] Caring for the dying patient is associated with higher levels of professional burnout.[11,12] Furthermore, inadequate training in communication skills contributes to the stress experienced by physicians after the death of a patient.[12–15] These skills can and should be taught and practiced. Phone calls that deliver bad news can and should be planned and rehearsed. The aftermath of these conversations

[1]Hospice and Palliative Medicine Fellow, National Institutes of Health, Bethesda, Maryland.
[2]School of Medicine Class of 2017, c/o Center for Biomedical Ethics and Humanities, University of Virginia School of Medicine, Charlottesville, Virginia.
[3]Sections of General Medicine and Palliative Care, Department of Medicine, Center for Biomedical Ethics and Humanities, University of Virginia School of Medicine, Charlottesville, Virginia.
Accepted December 6, 2016.

can be interpreted, shared, and applied, like any difficult experience, to the next challenging occasion.

Objectives

There are relatively few accounts in the published literature of structured and tested approaches to teaching healthcare providers how to conduct death notifications.[16–21] While the published opinion is unanimous that ideal death notification should occur in person, in practice this is not always possible and occasionally notification must occur by phone.[3,22–24] We used results of a literature review and open-ended interviews with faculty, residents, and widows to develop a survey regarding resident training and experience in death notification by phone.

The survey results will guide efforts to develop and standardize communication strategies that are specific to death notification conversations.

Design

We began by investigating the literature on medical education and communication. We reviewed published articles in English since 1980 using PubMed and the following search terms and key words: patient death, unexpected death, condolence, professional family relations, physician family relations, death notification, grief, emotions, family, death, role, physician's role, and correspondence. Based on the title and abstract of the article, we selected articles for detailed review. We checked the bibliographies of selected articles for more useful references. With IRB approval, we used e-mail to invite all internal medicine (IM) residents at our institution and a convenience sample of IM, Emergency Medicine, and Pediatric faculty to share their experience speaking to families of recently deceased patients. We also spoke to several colleagues who had been widowed in the last year. These open-ended interviews were conducted by telephone. The doctors described what it felt like to call the family, how and why they happened to be responsible for these calls, and how they prepared for the call. The widows had previously expressed interest in sharing their experience at the receiving end of these phone calls.

Based on recommendations from the published literature and these interviews, we developed a 30-item survey that we sent to all IM residents. We assumed that a survey conducted by an IM resident would seem valid to that residents' peers, but we did not formally test the survey's validity. The survey probed residents about their training in death notification and their experience talking to families, including conversations by telephone. The text of the survey is posted online (http://med.virginia.edu/biomedical-ethics/wp-content/uploads/sites/129/2015/10/Death-Notification-Survey.pdf). The survey was conducted by e-mail.

Measurement and Results

We identified 56 relevant articles, but only six articles included results of structured approaches to teaching and conducting these phone calls. Of these six articles, five discussed experience in emergency department settings.[17–21] One article described a notification training program for IM residents.[16] Eleven articles surveyed families, friends, or survivors of an accident that killed the patient.[2,3,25–33] Six articles surveyed health professionals on death notification practices.[22,34–38] There was one chart audit,[39] and there were 29 review articles describing notification in the emergency department and hospital.[6,23,24,40–65] Three articles subjectively commented on death notification conducted by telephone, but none described this method beyond suggesting that it should be avoided.[3,22,24] However, no articles explained how to avoid telephoning the families about deaths without in effect lying about what happened and delaying the bad news until a face-to-face meeting could be arranged.

Of 93 IM residents, 67 (72%) completed the survey. Seventy-three percent of responders reported having made a telephone call themselves to notify a family of an inpatient death. Eighty percent of residents felt inadequately trained to perform this task and 27% reported that calls went poorly. Attending physicians were involved in the notification process in only 17% of cases.

Residents were surveyed about the call itself, including preparation, content, and outcome. A minority of residents prepared for the death notification phone call when the death was expected, and only 53% of respondents prepared when the death was unexpected.

Knowing that arrival to the hospital, spending time with the body, and following up with the survivors after the death are important factors in the bereavement process,[2,3,5,33] we asked residents how often they perform these practices. Sixty percent addressed safe travels to the hospital and greeted the family upon their arrival. A majority spent time with family at the bedside, but only a small minority reported involvement in any follow-up practice, such as notifying the patient's primary care physician or writing a condolence letter.

The survey included qualitative questions used to assess features of calls that went well or went poorly. Most residents had experienced calls that went better than expected. Their commentary suggests that this occurred when the physician had established a good relationship with the family before death, when the death was not unexpected, and when the physician took time during the telephone call to express empathy and explain the details of the death. In contrast, calls went poorly usually in the case of unexpected deaths, when the explanation of the death was unclear or when the notifying resident was not familiar with the family.

As per Table 1, there was no consistent approach to rehearsing the call, making the call, advising families about a safe journey to the hospital, greeting families at the hospital, notifying the deceased patient's PCP, or following up with the family with condolence phone calls or notes.

Table 1. Resident Behaviors: Expected versus Unexpected Deaths

	Expected deaths, %	*Unexpected deaths, %*
Prepare for call	15	53
Discuss safe arrival	38	60
Greet family upon arrival	47	60
Spend time with family next to body	55	80
Notify PCP	13	13
Write or sign condolence letter	11	13
Delay notification until family arrived at hospital	0	0

Conclusions

Who should make death notification phone calls? Residents accept this responsibility and are reluctant to pass it on. They know the clinical details, but need to learn how to convey them during moments of despair. If the death was unexpected, residents should talk to someone about how to make the call, what to say, and what to suggest. We encourage them to discuss the calls in advance with their attending or the patient's primary care doctor or the on-call chaplain. In addition, we encourage residents to include floor and ICU nurses in planning for the call. The nurse may know the family better than anyone and may want to join the conversation.

What should the resident say? The content of the calls is situation specific, but in a follow-up forum with residents who completed our survey, they asked for suggestions on how to introduce the call and requested an outline of topics that should be covered during the conversation. The death notification and certification process will soon be part of the electronic health record (EHR), and based on this study we have permission to insert links to outlines, scripts, and templates that will help guide not only these phone calls but also expressions of condolence.

Should the family be summoned by phone and then informed of the death, face to face, at the hospital? None of the residents or faculty we talked to felt capable of lying to the family in an effort to make the drive to the hospital less frantic. It is important to remind families to take care with travel and to summon help, if available, for making the drive. Many of our patients live 30 minutes or more from the hospital. The drive for the family, late at night on country roads, may be extraordinarily risky.

Should medical curriculum include communication skill training with opportunities for practice? Of course, and this training should begin in medical school. However, residents, fellows, and attendings all appreciate that the only way to really know what you are doing is to be accountable for doing it well.

This study is the first to describe current practices of telephone-conducted death notification by IM residents. With inclusion of the notification process in the EHR, it will be possible to monitor resident experience and competence, obtain systematic feedback about helping residents and families share the worst news anyone ever gives or receives, and do a better job supporting residents who become second or third victims after unexpected deaths from error of omission or commission.

The major limitation of the study is its small sample size and the limited experience that residents have with unexpected deaths.

When our patients die, we become, at least temporarily, the caretakers of those they have left behind. Our words instantly usher the newly bereaved into a changed life, lived now in the fresh absence of someone loved. Death notification is a responsibility and a skill that can be learned and practiced. The art of healing begins and ends with communication.

Acknowledgment

An abstract of this study was presented at the 2015 International Conference on Communication in Health Care, New Orleans, LA.

Author Disclosure Statement

No competing financial interests exist.

References

1. Didion J: *The Year of Magical Thinking*. New York: Random House, 2005.
2. Parrish GA, Holdren KS, Skiendzielewski JJ: Emergency department experience with sudden death: A survey of survivors. Ann Emerg Med 1987;16:792–796.
3. Leash RM: Death notification: Practical guidelines for health care professionals. Crit Care Nurs Q 1996;19:21–34.
4. Casarett D, Kutner JS, Abrahm J; End-of-Life Care Consensus Panel. Life after death: A practical approach to grief and bereavement. Ann Intern Med 2001;134:208–215.
5. Jurkovich GJ, Pierce B, Pananen L, Rivara FP: Giving bad news: The family perspective. J Trauma 2000;48:865–870.
6. Stewart AE: Complicated bereavement and posttraumatic stress disorder following fatal car crashes: Recommendations for death notification practice. Death Stud 1999;23: 289–321.
7. Mostofsky E, Maclure M, Sherwood JB, et al: Risk of acute myocardial infarction after death of a significant person in one's life: The Determinants of MI Onset Study. Circulation 2012;125:491–496.
8. Parkes CM, Brown RJ: Health after bereavement: A controlled study of young Boston widows and widowers. Psychosom Med 1972;34:449–461.
9. Stroebe M, Schut H, Stroebe W: Health outcomes of bereavement. Lancet 2007;370:1960–1973.
10. Helsing KJ, Szklo M: Mortality after bereavement. Am J Epidemiol 1981;114:41–52.
11. Redinbaugh EM, Sullivan AM, Block SD, et al: Doctors' emotional reactions to recent death of a patient: Cross sectional study of hospital doctors. BMJ 2003;327:185.
12. Jackson VA, Sullivan AM, Gadmer NM, et al: ''It was haunting…'': Physicians' descriptions of emotionally powerful patient deaths. Acad Med 2005;80:648–656.
13. Molassiotis A, van den Akker OB, Boughton BJ: Psychological stress in nursing and medical staff on bone marrow transplant units. Bone Marrow Transplant. 1995;15:449–454. Erratum in: Bone Marrow Transplant 1995;16:328.
14. Whippen D, Canellos G: Burnout syndrome in the practice of oncology: Results of a random survey of 1,000 oncologists. J Clin Oncol 1991;9:1916–1920.
15. Kvale J, Berg L, Groff J, Lange G: Factors associated with Residents' attitudes toward dying patients. Fam Med 1999; 31:691–696.
16. Tolle SW, Cooney TG, Hickam DH: A program to teach residents humanistic skills for notifying survivors of a patient's death. Acad Med 1989;64:505–506.
17. Adamowski K, Dickinson G, Weitzman B, et al: Sudden unexpected death in the emergency department: Caring for the survivors. CMAJ 1993;149:1445–1451.
18. Benenson RS, Pollack ML: Evaluation of emergency medicine resident death notification skills by direct observation. Acad Emerg Med 2003;10:219–223.
19. Hobgood C, Harward D, Newton K, Davis W: The educational intervention ''GRIEV_ING'' improves the death notification skills of residents. Acad Emerg Med 2005;12: 296–301.
20. Hobgood C, Mathew D, Woodyard DJ, et al: Death in the field: Teaching paramedics to deliver effective death notifications using the educational intervention ''GRIEV_ING.'' Prehosp Emerg Care 2013;17:501–510.
21. Schmidt TA, Norton RL, Tolle SW: Sudden death in the ED: Educating residents to compassionately inform families. J Emerg Med 1992;10:643–647.

22. Tolle SW, Girard DE: The physician's role in the events surrounding patient death. Arch Intern Med 1983;143: 1447–1449.
23. Robinson MA: Telephone notification of relatives of emergency and critical care patients. Ann Emerg Med 1982;11: 616–618.
24. Soreff SM: Sudden death in the emergency department: A comprehensive approach for families, emergency medical technicians, and emergency department staff. Crit Care Med 1979;7:321.
25. Fraser S, Atkins J: Survivors' recollections of helpful and unhelpful emergency nurse activities surrounding sudden death of a loved one. J Emerg Nurs 1990;16:13–16.
26. Janzen I, Cadell S, Westhues A: From death notification through the funeral: Bereaved parents' experiences and their advice to professionals. Omega 2004;48:149–164.
27. Jones WH: Emergency room sudden death: What can be done for the survivors? Death Educ 1978;2:231–245.
28. Lehman DR, Ellard JH, Wortman CB: Social support for the bereaved: Recipients' and providers' perspectives on what is helpful. J Consult Clin Psychol 1986;54:438–446.
29. Marco CA, Wetzel LR: Communication with survivors of motor vehicle crashes. Emerg Med J 2012;29:626–629.
30. Merlevede E, Spooren D, Henderick H, et al: Perceptions, needs and mourning reactions of bereaved relatives confronted with a sudden unexpected death. Resuscitation 2004; 61:341–348.
31. Parris RJ, Schlosenberg J, Stanley C, et al: Emergency department follow-up of bereaved relatives: An audit of one particular service. Emerg Med J 2007;24:339–342.
32. Pullen S, Golden MA, Cacciatore J: ''I'll never forget those cold words as long as I live'': Parent perceptions of death notification for stillbirth. J Soc Work End Life Palliat Care 2012;8:339–355.
33. Tolle SW, Bascom PB, Hickam DH, Benson JA, Jr.: Communication between physicians and surviving spouses following patient deaths. J Gen Intern Med 1986;1:309–314.
34. Schmidt TA, Tolle SW: Emergency physicians' responses to families following patient death. Ann Emerg Med 1990; 19:125–128.
35. Stewart AE, Lord JH, Mercer DL: A survey of professionals' training and experiences in delivering death notifications. Death Stud 2000;24:611–631.
36. Swisher LA, Nieman LZ, Nilsen GJ, Spivey WH: Death notification in the emergency department: A survey of residents and attending physicians. Ann Emerg Med 1993;22:1319–1323.
37. Tolle SW, Elliot DL, Hickam DH: Physician attitudes and practices at the time of patient death. Arch Intern Med 1984;144:2389–2391.
38. Viswanathan R, Clark JJ, Viswanathan K: Physicians' and the public's attitudes on communication about death. Arch Intern Med 1986;146:2029–2033.
39. Tolle SW, Hickam DH, Elliot DL: A comparison of men and women physicians' management of patient death. West J Med 1985;143:691–693.
40. Baker HM: Some thoughts on helping grieving families. J Emerg Nurs 1987;13:359–362.
41. Bedell SE, Cadenhead K, Graboys TB: The doctor's letter of condolence. N Engl J Med 2001;344:1162–1164.
42. Clements PT, DeRanieri JT, Vigil GJ, Benasutti KM: Life after death: Grief therapy after the sudden traumatic death of a family member. Perspect Psychiatr Care 2004;40:149–154.
43. Collins S: Sudden death counseling protocol. Dimens Crit Care Nurs 1989;8:376–382.
44. Dubin WR, Sarnoff JR: Sudden unexpected death: Intervention with the survivors. Ann Emerg Med 1986;15:54–57.
45. Edlich RF, Kubler-Ross E: On death and dying in the emergency department. J Emerg Med 1992;10:225–229.
46. Hafner J, Geldmacher K: Death notification and grief response in the emergency department. Emerg Med Rep 2005; 26:1–8.
47. Haglund WD, Reay DT, Fligner CL: Death notification. Am J Forensic Med Pathol 1990;11:342–347.
48. Hamilton GC: Sudden death in the ED: Telling the living. Ann Emerg Med 1988;17:382.
49. Helm A, Mazur DJ: Death notification: Legal and ethical issues. Dimens Crit Care Nurs 1989;8:382–385.
50. Holland L, Rogich LE: Dealing with grief in the emergency room. Health Soc Work 1980;5:12–17.
51. Iserson KV: Notifying survivors about sudden, unexpected deaths. West J Med 2000;173:261–265.
52. Kent H, McDowell J: Sudden bereavement in acute care settings. Nurs Stand 2004;19:38–42.
53. Levetown M: American Academy of Pediatrics Committee on Bioethics. Communicating with children and families: From everyday interactions to skill in conveying distressing information. Pediatrics 2008;121:e1441–e1460.
54. Olsen JC, Buenefe ML, Falco WD: Death in the emergency department. Ann Emerg Med 1998;31:758–765.
55. Purves Y, Edwards S: Initial needs of bereaved relatives following sudden and unexpected death. Emerg Nurse 2005; 13:28–34.
56. Rando T: The increasing prevalence of complicated mourning: The onslaught is just beginning. Omega 1992;26:43–59.
57. Roe E: Practical strategies for death notification in the emergency department. J Emerg Nurs 2012;38:130–134.
58. Rutkowski A: Death notification in the emergency department. Ann Emerg Med 2002;40:521–523.
59. Shoenberger JM, Yeghiazarian S, Rios C, Henderson SO: Death notification in the emergency department: Survivors and physicians. West J Emerg Med 2013;14:181–185.
60. Tolle SW, Elliot DL, Girard DE: How to manage patient death and care for the bereaved. Postgrad Med 1985;78:87–89.
61. Vallurupalli M: Mourning on morning rounds. N Engl J Med 2013;369:404–405.
62. Von Bloch L: Breaking the bad news when sudden death occurs. Soc Work Health Care 1996;23:91–97.
63. Walters DT, Tupin JP: Family grief in the emergency department. Emerg Med Clin North Am 1991;9:189–205.
64. Wolfson R, Menkin E: Writing a condolence letter. J Palliat Med 2003;6:77–78.
65. Yates DW, Ellison G, McGuiness S: Care of the suddenly bereaved. BMJ 1990;301:29–31.

Address correspondence to:
Daniel Becker, MD
Sections of General Medicine and Palliative Care
Department of Medicine
Center for Biomedical Ethics and Humanities
University of Virginia School of Medicine
Box 800758
Charlottesville, VA 22908

E-mail: dmb2y@virginia.edu