

HANDLING DISTRESSED RELATIVES AND BREAKING BAD NEWS

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Problems associated with breaking bad news in cases of trauma

- Death or severe injury is sudden and unexpected
- The victim is often young
- The prognosis is often unsure
- Staff are often very busy
- Relatives may already have been notified in an unskilled manner
- The victim may have committed suicide
- Alcohol intoxication may have been a contributing factor

Coping with major trauma is stressful for both staff and the relatives. Handling distressed relatives is an underemphasised part of the work, and medical staff may have had no training and little experience of it. It is a time that the relative will always remember and, if handled badly, will leave lasting scars.

Various outcomes of major trauma

- Death
- Serious head injury
- Multiple injuries
- Spinal injury
- Major burns
- Loss of a limb
- Loss of sight

Giving bad news is never easy, but it can be especially difficult in cases of major trauma. The nature of the patient's problem and the bad news can be very varied. The management of the relatives may begin before they arrive at hospital and carry on until well after death or discharge of the patient. The principles of management apply to the accident and emergency department as well as the intensive treatment unit or admitting ward. Providing genuine understanding and support for relatives is the key to their management.

Initial contact

When a victim of major trauma arrives in the emergency room the priority is immediate resuscitation. Once the victim has been identified the closest relatives or friends should be notified.

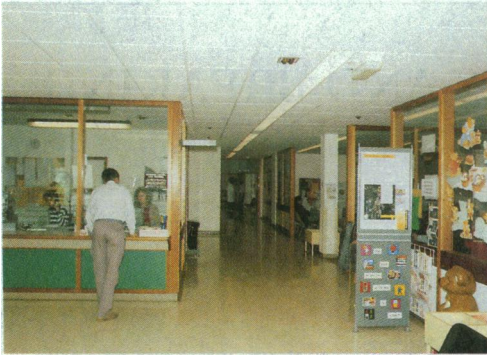
Handling the initial contact with relatives

- It may be preferable for a police officer to make contact in person
- Information on the telephone should be given by an experienced nurse or doctor
- Relatives should not drive to hospital alone
- The full severity of injuries or death may be best explained at the hospital

Communication with the emergency services is very important. The ambulance crew and police, as well as giving information on the incident, may have already seen the relatives or know their whereabouts. It is usually better for a sympathetic police officer to make the initial contact in person rather than for a telephone call to be made from the hospital. The police may also be able to help with transport.

If the telephone is used information should be given by an experienced nurse or doctor and a lone relative advised strongly against driving to hospital alone. Mentioning that the victim is unconscious often helps to impart a certain severity to the lay person, although the full severity or death is usually best explained in person at the hospital. If relatives are not told of the victim's death, however, they may blame themselves for not arriving at the hospital in time to be with their loved one at death. It is important to dispel any self recrimination by giving the relatives the exact information, including the time of death. If the relatives have to travel great distances or from overseas the full details, including death, may have to be explained over the telephone. Find out if the relative is alone and, if so, suggest that he or she seeks support locally. Offer to telephone for support.

Arrival of relatives at the hospital



Distressed relatives should be given privacy and not kept waiting in reception areas, which may be impersonal and busy.

Breaking the news

Essential features of a relatives' room

- Privacy
- Telephone
- Hand basin
- Mirror
- Appropriate decor and furniture
- Advice and information leaflets (out of sight)
- Tea cups



Relatives' room.

Some immediate grief reactions

- Numbness—that is, acceptance but no feeling
- Disbelief
- Acute distress
- Anger—including that against the medical care; blaming themselves or others
- Guilt
- Acceptance

Anxious relatives should be met by a nurse and not be kept waiting around at reception for the department's or ward's communications to be established. Therefore, it is important that the nursing sister coordinates the information so that the staff, in particular those at reception, know that potentially distressed relatives are expected. They should be welcomed and not made to feel in the way. Staff should remember that it is not only the victim's relatives who may be distressed: in some instances close friends may be severely distressed and should be handled in the same way as the relatives.

There should be a private room or office where relatives and friends can wait and be seen. Ideally this room should be solely for relatives and friends and be suitably furnished.

Remember to ask relatives for the medical history of the patient. This history may be vital if the patient is receiving certain drugs such as steroids or anticoagulants, and an idea of the quality of life may be useful in elderly victims or those with disease. Providing a history can also make relatives feel less helpless and that they are doing something.

During attempted resuscitation relatives should at least be given early warning if the condition is critical. Regular updates by the same person (usually a nurse) are also appreciated and may help to break the bad news in stages. It also allows relationships to form, which will help in providing the support that may be needed later.

The contact nurse should introduce a doctor, preferably a senior one to the relatives as soon as possible to provide further information. Relatives expect to see a doctor for medical information and an idea of the prognosis: "Will he be alright, doctor?"

Advice for the doctor

Breaking bad news has to be tailored to the situation and the particular relatives, but the following principles generally apply:

- On leaving the resuscitation area or theatre you may be stressed, so take a moment to compose yourself and think about what you are going to say. Also remove evidence of blood stains, etc, so that you are physically and mentally prepared
- Take an experienced nurse with you. A nurse can be a great support and can carry on where you leave off
- Confirm that you have the correct relatives and who's who. Ascertain what information they already have
- Enter the relatives' room, introduce yourself, and sit down near the patient's closest relative. Do not stand holding the door handle like a bus conductor ready to jump out. Giving the impression that you have time to talk and listen is important
- In general look at who you are talking to, be honest and direct, and keep it simple. Be prepared to emphasise the main points. Avoid too much technical information at this stage (although with patients with multiple injuries there may be much going on). If death is probable say so; do not beat about the bush
- After breaking bad news allow time and some moments of silence while the facts sink in
- Be prepared for a variety of emotional responses or reactions. Some people may stick at one reaction whereas others go through several reactions
- Allow and encourage reactions such as crying. Provide tissues and facilities for relatives to make themselves presentable to the world again
- Although it is upsetting, close relatives appreciate the truth and your honest empathy
- At this stage there is no substitute for genuine understanding and support. A sensitive nurse is a great asset



A sensitive nurse is a great asset after the news has been broken.

Staff actions during the interview with the bereaved

Allow

- Time
- The bereaved to react
- Silence
- Touching
- Questions

Avoid

- Rushing
- "Protecting" from the truth
- Platitudes
- False sympathy
- Euphemisms

Whenever possible relatives should be given a clear explanation of the cause of death

- Tea usually appears, and this is another sign that the relatives' distress is appreciated
- During the interview it is a helpful and natural comfort for staff to touch or hold the hand of the relative. Various social and cultural factors may influence the appropriateness of touching, but generally if it comes naturally then it is probably right
- Likewise, during the interview it may be natural for the staff to have sad feelings, and these need not be completely hidden. Some sign of emotion may help distressed or bereaved people to realise that the staff do have some understanding and it is not just another case
- Avoid platitudes—for example, after a death comments such as "you've still got your other son, etc," which are not helpful as it is the dead person whom the relatives want back. Also avoid false sympathy as in "I know what it's like," but rather empathise, as in: "It must be hard for you. . ." or "It must feel very unreal. . .," etc, reflecting back their emotions.

Encourage and be prepared for questions to be asked during the interview. These may disclose any misunderstandings and present a chance to re-emphasise the message. The question of pain and suffering is common and should be discussed routinely, with reassurance as appropriate. The prognosis may be unknown initially, and you should say so. If death or serious disability is possible, however, then it is only fair to be honest and warn the relatives. It will be a worse shock later if they have been protected from this knowledge. Do not be afraid to answer that you do not know the answers to medical or philosophical questions such as "Why me?" Other difficult questions may arise from feelings of guilt or when a relative was involved in but not injured in the same accident. Special problems may arise if the relative feels responsible directly—for example, as the driver in an accident. Other complications may include a recent squabble before the accident with subsequent self recrimination. The "If only. . ." rumination can be a type of guilt response that is fruitless and should be understood but discouraged at the outset.

If death has already occurred the same principles as discussed above apply. It is important to use the word "death" or "dead" early and avoid euphemisms such as "passed on." The news is usually hard to accept and so it must be as clear as possible, abrupt as it may seem. People usually need an explanation as to the cause of death of a loved one. It may be helpful to explain the inevitability in the light of known injuries and that "everything possible was done." Worries about their own first aid at the scene of the accident may need talking through.

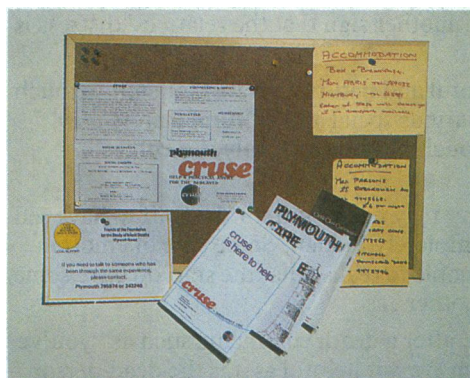
Children should not be excluded from the proceedings in the mistaken belief that they need protection. They will be afraid and may have fantasies and feelings of guilt and need information.

Management of relatives

Reality is preferable to fantasy so allow relatives to see even critically ill patients, albeit briefly

Seeing the patient

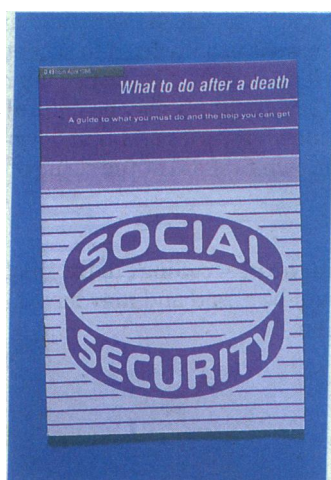
Depending on urgency of further treatment it should usually be possible for close relatives briefly to see the patient before he or she is rushed off to theatre, the intensive treatment unit, or even another hospital. Although distressing, reality is usually preferable to fantasy. Also, sometimes this may be the last time that they will see their loved one alive. In addition, this contact may be beneficial to the conscious patient. Relatives may ask to enter or remain in the resuscitation area during emergency treatment, especially of infants and children. This is not yet generally accepted, but it seems that it can be beneficial provided that they are supported by an advocate such as a sensitive member of staff (for example, a relative who is a witness may better appreciate both the seriousness of the situation and the vigour of resuscitation efforts). Hospital staff may, however, be apprehensive about the presence of relatives, and their feelings must be considered.



Useful information in the relatives' room.

Checklist of actions in the event of death

- Notify the general practitioner, other relatives and friends, and the coroner's officer
- Ensure that the minister or chaplain has been called if the relatives wish
- Give an information or help leaflet to the relatives
- Notify the social worker if he or she is available
- Give useful telephone numbers and contact addresses (and your name) to the relatives



Leaflet explaining official procedures after death.

Difficulties for hospital staff in breaking bad news

- Lack of training and experience
- Fear of being blamed
- Not knowing how to cope with relatives' reactions
- Fear of expressing emotion
- Fear of not knowing the answers
- Fear of their own death or disability

Seeing the body after death

The opportunity to see the body after death should always be offered and gently encouraged if there is any doubt. Well meaning friends may try and discourage this act, which is an important part of accepting reality.

The imagination is usually far worse than reality, and cruel fantasies about the victim being disfigured or squashed flat can be dispelled. The actions and words of staff when relatives are with the body should give "permission" for relatives to touch, hold, kiss, or say goodbye to their loved one. Nurses will often carefully prepare a body before viewing in the clinical area or chapel. The relative may also like to be left alone with the body.

Other actions

Although they are stunned by events, it is often the small touches of care that relatives appreciate and remember, such as being given a lock of hair from their dead child by a thoughtful nurse.

Always ask if there is anyone else whom the relatives would like to be contacted—for example, a close friend or a minister. The hospital chaplains can be a source of great support to both relatives and busy staff.

If a mechanism of counselling and follow up exists locally consider borrowing their expertise in appropriate cases of trauma.

Sedation may be requested for relatives, usually by a third party but is generally inappropriate as it dulls reality and may delay acceptance. Grieving cannot be avoided so easily.

Follow up

Long term management and bereavement counselling is not within the scope of this article, but arrangements for follow up may need initiating on day one. If the nurse or doctor concerned in the emergency department feels able they can offer to see the relative again. Some departments have a social worker who can provide some practical help as well as coordinate follow up. Further information from necropsy may also be available. If death occurs it is helpful to have a routine checklist, which includes notifying the general practitioner.

An up to date leaflet explaining official procedures slipped into a relative's pocket is useful for later perusal (for example, leaflet D49, *What to do after Death*, which is published by the Department of Health). Participation by the coroner's officer, who may be a policeman, should be explained. Warning relatives of the possibility of them developing symptoms of post-traumatic stress disorder is appropriate in certain cases. (An explanatory leaflet that includes ways to get help would be useful in busy departments.) Such symptoms include depression, anxiety, and flash backs, with a wide range of severity. Also, it may be necessary in follow up to warn them of possible avoiding or unhelpful actions by neighbours. Details of any local organisations, such as CRUSE, from which help and practical advice can be obtained from trained counsellors, should also be given.

Staff's reaction

Lastly, do not forget the carers. There are many different reactions, the commonest of which are sadness, anger, and guilt.¹ Staff may identify with particular people or situations. For example, a child being killed will be particularly upsetting, especially for staff with children of the same age. Part of the debriefing on major trauma must include an opportunity for members of staff to express their feelings. Hiding behind a defence of excessive concern with composure or tasks should be avoided.

Conclusion

National contact addresses

- **CRUSE** (for care of the bereaved) Cruse House, 126 Sheen Road, Richmond, Surrey TW9 1UR. Tel (071) 940 4818
- **Compassionate friends** (for bereaved parents) 6 Denmark Street, Bristol BS1 5DQ. Tel (0272) 292778
- **Foundation for the Study of Infant Deaths** 15 Belgrave Square, London SW1X 8PS. Tel (071) 235 1721
- **Samaritans** (for the despairing) 17 Uxbridge Road, Slough SL1 1SN. Tel (0753) 32713

Because of its suddenness and severity major trauma is especially difficult for relatives and staff to cope with. However bad the news is relatives need direct, honest information along with genuine understanding and support. Many doctors find this important part of their work difficult. Reasons have been suggested for this.² Awareness may help the situation and lead to a greater emphasis in training.

In short, the principles of dealing with the distressed relative can be remembered as follows:

- **Empathise.** Sit and listen to and reflect back relatives' reactions rather than make assumptions or categorise them
- **Enable** relatives to accept reality and to experience the pain
- **Encourage**, as in "you will be able to cope" (with help if needed)
- **Encounter** your own feelings and express them later, perhaps as part of a debriefing.

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- 1 Wright B. Sudden death: aspects which incapacitate the carer. *Nursing* 1988;3:12-5.
- 2 Buckman R. Breaking bad news: Why is it still so difficult? *BMJ* 1984;288:1597-9.

Letter from... Chicago

Dog days

George Dunea

The new interns arrive on the first day of July. They are herded into a large auditorium and overwhelmed for eight hours with detailed instructions that they cannot possibly remember and platitudes that they have all heard before. They must work hard, learn a lot, sharpen their skills, strive to be complete persons, have fun, and become members of the team. They are given a titillating description of the great beauties of the American landscape: cost containment, the need for documentation, quality assurance, managed care, peer review, malpractice, utilisation review, and interdisciplinary rounds. They are then taken to the wards and told to draw blood.

This is the time of the year when anybody who knows anything about teaching hospitals makes an effort to stay away. The patients try to reschedule their coronary thromboses. The wise hospital superintendents of olden days went on vacation. But modern scientists prefer to collect data to quantify this July phenomenon. Recently they studied 2589 patients and found nothing wrong. Then they studied another 21 679 patients and merely discovered that at this time of the year they stayed in hospital on average half a day longer. It seems that nobody died needlessly and that "it is OK to get sick in July." In the face of this overwhelming statistical evidence on site observers may have to refrain in the future from describing the July changeover by such alarming epithets as harrowing, tumultuous, or cataclysmic.

This summer also witnessed an attempt to correct the federal budget deficit. The president and congress leaders met daily but agreed on nothing, not even on ending illogical programmes such as subsidising tobacco growing. Then the gulf crisis dispelled the

romantic notion of raising money by taxing oil imports. With oil on everybody's mind, and on many beaches as well, the Food and Drug Administration turned against fish oil. It was all right to take it, the administration said, if you didn't mind a "fishy burp" and paying \$1000 a year. But it was not acceptable, it had already decided some time ago, to claim that fish oil could cure migraine, arthritis, diabetes, eczema, psoriasis, hypertension, and cancer. Recently, and despite a British study presenting evidence to the contrary, the administration has also forbidden manufacturers to claim that fish oil could cure heart disease. It also has new proposals on labelling grocery products, eliminating the blurb about vitamins, and requiring the use of standard serving sizes. According to the new proposals, hailed as a major step forward, cholesterol free foods must contain less than 2 mg of cholesterol and less than 5 gm of fat per serving. Low cholesterol will mean less than 20 mg per serving. Data on saturated and unsaturated fat, fibre, cholesterol, carbohydrate, and sodium will have to be expressed as a percentage of what is contained in a 2350 calorie diet, allowing appropriate extrapolations for dieters.

Knife happy surgeons

Meanwhile the health bureaucrats persist in assessing quality of care by mortality rates, publishing volumes of useless data in defiance of common sense and now also of a study by the Rand Corporation that is "somewhere between cautious and extremely sceptical" about the value of this exercise. More helpful might be the information that in some suburban hospitals in Chicago 37% of all babies were delivered by a caesarean

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