



Fast Facts Core Curriculum

Emergency Medicine

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FAST FACTS AND CONCEPTS #4 DEATH PRONOUNCEMENT IN THE HOSPITAL

David E Weissman MD and Charlotte A Heidenreich MD

Background Physicians traditionally have little formal training in examining patients to determine death, notifying families, and in recording proper documentation. This *Fast Fact* reviews key steps in the death pronouncement and notification process. See also *Fast Facts* #76, 77 on telephone notification of death.

The Phone Call: “Please come and pronounce this patient”

- Find out the circumstances of the death from the nurse – expected or sudden? Is the family present?

Preparation Before You Enter the Room

- For residents, find out if the attending physician has been called. In general, see the patient before calling the attending, unless there are unusual family dynamics or details surrounding the death that you should discuss with the attending.
- Determine if the family has requested or if you believe there is value in requesting an autopsy. Some institutions have specific policies about autopsy requests.
- Determine if the patient/family has already been contacted by the Organ Donor Network (see *Fast Fact* #79 Discussing Organ Donation).
- Review the chart for important medical (length of admission, cause of death) and family issues (Who is family? Faith? Is there a clergy contact?).

In the Room

- You may want to ask the nurse or chaplain to accompany you; he/she can give you support and introduce you to the family.
- Introduce yourself (including your relationship to the patient) to the family. Ask each person their name and relationship to the patient.
- Empathetic statements are appropriate: “I’m sorry for your loss...” Or – “This must be very difficult for you...”
- Explain what you are there to do. Tell the family they are welcome to stay while you examine their loved one.
- Ask if family members have any questions or if they wish to speak with a chaplain.

The Pronouncement

- Identify the patient by the hospital ID tag. Note the general appearance of the body.
- Ascertain that the patient does not rouse to verbal or tactile stimuli. Avoid overtly painful stimuli especially if family members are present. Nipple or testicle twisting, or deep sternal pressure are inappropriate.
- Listen for the absence of heart sounds; feel for the absence of carotid pulse.
- Look and listen for the absence of spontaneous respirations.
- Record the position of the pupils and the absence of pupillary light reflex.
- Record the time at which your assessment was completed.

Documentation in the Medical Record

- Called to pronounce (name); Chart the findings of physical examination.
- Note date and time of death; Note if family and attending physician were notified.

- Document if family declines or accepts autopsy
- Document if the death was natural and if the coroner was notified.
- For the purposes of filling out the death certificate (see FF #155): document cause of death; length of time between onset of condition and death; and whether tobacco or alcohol may have contributed to the death.

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**FAST FACTS AND CONCEPTS #64
INFORMING SIGNIFICANT OTHERS OF A PATIENT'S DEATH**

Diane Midland BSW, MS

Introduction This *Fast Fact* reviews the components of a sensitive notification of loved ones when a patient dies. The physician is a key figure in the death notification process. Family and friends who are present at the time of death look to the physician for information, reassurance and direction regarding the weeks and months ahead. The lasting impression and memories that family members have regarding the manner in which they received word that their loved one died may affect the grief process and eventual integration of the loss within the survivors' world. Research has demonstrated that the skills of compassion and sensitivity can be learned and must be incorporated into the practice of all physicians.

Preparation

1. Confer with nursing and other staff working with the family/significant others. Review the medical record (including any advance directive).
2. Examine the patient; confirm death (see *Fast Fact #4*).
3. Find a private place to meet with family/significant others.
4. Involve other members of the interdisciplinary team (e.g. nurse or chaplain) in the notification process.
5. If possible, learn the names of those you will be talking with and their relationship to the deceased.

Meeting with the Family/Significant Others

1. Introduce yourself and identify those present. In situations where there are family and friends present, ask the next-of-kin who they would like with them during the conversation.
2. Identify and respect ethnic, cultural or religious traditions (see *Fast Fact #26*).
3. Invite those present to sit down with you. Use body language, eye contact and touch (introductory hand shake or clasp), if appropriate and accepted by family/significant others.
4. Express your condolence (e.g. *I'm sorry for your loss; My condolences to you and your family.*)
5. Talk openly about the death. Use "died" or "dead" during the initial conversation. Listen for the words used by the family/significant others to describe death and use their term(s) throughout the remaining discussion. Refer to the deceased by name.
6. If requested, explain the cause of death in non-medical terms. Allow time for questions; be open to acknowledging that there may be things you don't know. Offer assurance that everything possible was done to keep the patient comfortable.
7. Be prepared for a range of emotional expression. Do not offer sedation as a way to deal with expressions of emotion. (Mild sedation for a brief time period may be considered to assist with insomnia.)
8. Offer the opportunity to view the deceased. Prepare family/significant others for how the deceased will appear; model touching and talking to the deceased. Offer time alone with the deceased and assurance that survivors will not be rushed.
9. Provide time for the family/significant others to process the reality of the death before discussing autopsy or tissue/organ donation.
10. Let family/significant others know that you will return, should questions arise or they desire additional information. Provide information about how the family can reach you after they leave the facility.

Follow-up

1. Personalize and sign a sympathy card to the bereaved (see *Fast Fact #22*).
2. Consider attending the wake, funeral, or memorial service.
3. Consider referral to a bereavement support service or agency, particularly if children are involved.

4. Encourage the bereaved to schedule a physical exam four to six months after the death.
5. Invite the bereaved to meet with you regarding autopsy results or to discuss unresolved questions.

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FAST FACTS AND CONCEPTS #76
TELEPHONE NOTIFICATION OF DEATH – Part I

Rosalia R Osias MD, Daniel H Pomerantz MD, Jeffrey M Brensilver MD, FACP

Background Telephone notification to family members about a death is one of the most challenging and stressful communication skills, especially for cross-covering housestaff who may have had no direct interactions with the patient or family. Unpredictable variables are involved; telephone notification does not allow the same level of interaction possible with direct personal contact. This *Fast Fact* offers some guidelines when telephone notification is unavoidable; *Fast Fact #77* discusses issues surrounding whether or not to delay notification of death until loved ones arrive at the hospital.

I. Preparing for the Call

1. Review death pronouncement protocol (See *Fast Facts # 4* and 64).
2. Positively identify the patient (hospital ID tag) and confirm death.
3. Obtain relevant information; e.g. patient's name, age, gender, identification numbers.
4. Obtain the full name, address, phone number(s) of the person/s you are calling. Try to establish from the chart and nursing staff the relationship of the contact to the deceased patient.
5. Establish the circumstances of death; expected or sudden. Write down the key information you need and thoroughly review what you will say.
6. Find a quiet or private area with a phone.

II. Timing

The call should be made as soon as possible following the death. *Whenever possible, inform the family of a grave turn of events prior to the patient dying.* When substantial delay is likely, the responsibility for informing the family should be taken by the covering doctor (or the resident).

III. The Actual Notification

1. Identify yourself. Ask the identity of the person you are talking to and their relationship to the patient. Ask to speak to the person closest to the patient (ideally, the health care proxy or the contact person indicated in the chart). Avoid responding to any direct question until you have verified the identity of the person to whom you are speaking. Ask if the contact person is alone. Do not give death notification to minor children.
2. If you do not have a prior relationship with the person you are speaking to, ask what they know about the patient's condition: *What have the doctors told you about _____'s condition?*
3. Provide a warning shot: *I'm afraid I have some bad news.*
4. Use clear and direct language, no medical jargon: *I'm sorry, _____ has just died.* Words like "dead" or "died" should be used. "Expired", "passed away" or "didn't make it" can be misinterpreted.
5. Speak clearly and slowly, allow time for questions. Be empathetic. A perceptive family can easily tell whether the notifier cares or is merely "going through the motions."
6. If the family chooses to come to see the body, arrange to meet them personally.
7. Provide contact information for the physician or hospital official who can meet with them and answer questions about the patient's death and other administrative issues.
8. Ask if you can contact anyone for them. Assess their emotional reaction (see *Fast Fact #77*).
9. If you feel uncomfortable about telephone notification, ask for help.
10. *Never* deliver the news of death to an answering machine or voice mail. Instead, leave specific contact information. If you are unable to make contact within 1-2 hours, contact a hospital representative (e.g. social worker) to assist you in locating family or others.

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FAST FACTS AND CONCEPTS #77 TELEPHONE NOTIFICATION OF DEATH – PART II

Rosalia R Osias MD, Daniel H Pomerantz MD, Jeffrey M Brensilver MD, FACP

Introduction In Part I (*Fast Fact # 76*), the basic steps and precautions of telephone notification of death were outlined. This *Fast Fact* discusses the dilemma of whether to provide telephone information versus asking family members to first come to hospital before telling them that death has occurred.

Delay vs. Disclose Immediately Few would disagree that it is always preferable to present death notification in person. However, when families live at a great distance, or are physically unable to travel, telephone discussion will be necessary. In other situations, clinicians must weigh the benefits of truthfulness against the risk of potential harm resulting from abrupt disclosure of the bad news. Factors to consider in making this decision include:

- Whether death was expected or not, including the nature and chronicity of the illness.
- How well the death notifier knows the patient and the patient's family.
- The relationship of the contact person to the patient.
- The anticipated emotional reaction of the contact person based on prior information.
- Whether the contact person will be alone when receiving the information
- The contact person's level of understanding.
- Distance, availability of transport, and time of day.

For example, when death is expected due to progressive cancer and the notifier knows both the patient and the contact person, telephone notification is very acceptable. In fact, you should have prepared for this moment ahead of time by asking the contact how he or she wishes to be contacted at the time of death. In contrast, if the death is sudden, especially of a minor, notification in person is always preferred, although time and distance issues may make this impractical.

The notifier must be prepared to quickly integrate all these factors to decide whether to reveal that the patient is dead, or whether to describe the patient as gravely ill and request that the contact person come to the hospital immediately. If you decide to delay disclosure of the death, be prepared to make immediate admission of such nondisclosure as soon as you meet the family (e.g. *I'm sorry for not telling you the whole thing right away over the phone;* then give your reason for doing so).

Responding to Emotions Whether in person or by telephone, you should expect an emotional reaction to the death notification (see *Fast Fact #29*). Responding to emotions via telephone is especially difficult. Some tips include:

- Ensure that the contact has someone else with them. Offer to contact family members, friends, clergy or others.
- Offer to meet with the contact in person.
- Contact your hospital social worker for advice on contacting other local resources such as the Red Cross, local police, or other service agencies.

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1. Iserson KV. The gravest words: sudden-death notification and emergency care. *Ann Emerg Med.* 2000; 36:75-77.
2. Iserson KV. The gravest words: notifying survivors about sudden, unexpected deaths. *Resident and Staff Physician.* 2001; 47:66-72.

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FAST FACTS AND CONCEPTS #155 COMPLETING A DEATH CERTIFICATE

Nikkisha Prentice and Robert Arnold MD

Background Physicians are responsible for providing proper documentation of death. This *Fast Fact* reviews key steps in the completion of a death certificate.

Importance of Proper Completion Death certificate information is a permanent record of death. It is usually necessary for burial and settlement of the deceased's estate. Documentation of the cause of death, in addition to direct communication, may provide family members with closure and peace of mind. Death certificates are also used to 1) evaluate the general health of the population, 2) assess the prevalence of medical problems among specific groups, 3) triage medical research needs, and 4) apportion health services, grants, and other resources to common illnesses.

Basic Guidelines Death certificates are governed by state statutes; variations exist in who can complete a death certificate and how they should be filled out. Certification and completion of death certificates is usually the primary responsibility of the attending physician. However, in some states, death may be certified by the attending advanced practice nurse.

- Verify the correct spelling of names.
- Personally sign the death certificate; stamps are unacceptable.
- Complete all required items. If necessary, write "unknown" or "pending further study."
- Common Errors
 - Do not delay completion of the certificate. Some states have specific time periods and civil and/or criminal penalties for non-completion. Moreover, funeral homes will typically not proceed with burial without the death certificate.
 - Do not use abbreviations.
 - Some state forms require you spell out the month.
 - Use 24 hour clock rather than 12:00 midnight.
 - Some state forms do not allow alteration of the document; avoid erasing or using white-out.
 - Avoid cursive writing; print clearly or type using black ink.

Causality of Death This section of the certificate often consists of two parts. The first part asks for a sequential chain of events that led to death and the time interval between onset of a condition and death. The most immediate cause of death is stated on line *a* and the underlying causes follow on lines *b*, and so on. In assessing the approximate interval between onset and time of death, terms such as "unknown" or "approximately" may be used and general terms such as "minutes," "hours," and "days" are acceptable. The second part asks about other significant conditions that contributed to death, but that did not result in the underlying cause stated previously.

Mechanism vs. Cause of Death It is important not to write the *mechanism* of death (i.e. cardiac arrest, respiratory arrest) as the *cause* of death. The mechanism of death is the physiologic derangement or biochemical disturbance by which the cause of death exerts its lethal effect. *For accurate public health records, the cause of death (e.g. chronic obstructive pulmonary disease) is more helpful than the mechanism of death (e.g. respiratory failure).* When there is doubt as to the cause of death, it is acceptable to enter "unknown" or "pending further study." In some states, a condition may also be listed as "probable." As additional medical information, such as an autopsy report, becomes available, the certifying physician should report amendments to the state vital records office or local registrar.

Note: Listed below are common terms and definitions that are generally interchangeable between states. The table presents some examples.

- **Immediate (or Principle) Cause** = Final complication resulting in death.

- **Intermediate (or Antecedent or Underlying) Cause** = Disease or condition causing the immediate cause of death.
- **Underlying (or Contributory) Cause** = The condition present before and leading to the intermediate or immediate cause of death.

	Example 1	Example 2	Example 3	Example 4
Line A	Acute Myocardial Infarction	Acute Exacerbation of Obstructive Airway Disease	Pulmonary Embolism	<i>Pneumocystis jiroveci pneumonia</i>
Line B	Coronary Artery Disease	Chronic Bronchitis	Deep Venous Thrombosis	Acquired Immunodeficiency Syndrome
Line C	Chronic Ischemic Heart Disease		Metastatic Non-Small Cell Lung Cancer	Human Immunodeficiency Virus
Mechanism of death	Cardiac Arrest	Respiratory Arrest	Respiratory Arrest	Septic Shock
Other Significant Conditions	Diabetes	Smoking	Stroke, Hemiparesis	

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FAST FACTS AND CONCEPTS #246 EMERGENCY DEPARTMENT MANAGEMENT OF HOSPICE PATIENTS

Sangeeta Lamba MD, Tammie E Quest MD, David E Weissman MD

Background Patients enrolled in hospice programs will occasionally be transported to the Emergency Department (ED). Emergency medicine training focuses on life-prolonging measures and may fail to address hospice as a system of care. This *Fast Fact* provides information for clinicians practicing in EDs on management issues when a hospice patient arrives. *Fast Fact* #247 discusses initiating hospice care from the ED and #298 addresses Palliative Care Consultation in the ED.

Why do Hospice Patients come to the ED? ED providers should never assume that arrival in the ED equates a desire for aggressive/life-prolonging treatment. Even when a patient/family requests such services, an assessment is needed to understand the concerns that prompted a shift in care goals. Frequently such requests arise from fear about the dying process or guilt about prior medical decisions to limit life-prolonging treatments. Common triggers for an ED visit include:

- Stress/inability to cope with impending loss of life. This may be expressed as a request to start a life-prolonging treatment previously used and discontinued (e.g. chemotherapy) or never begun (e.g. renal dialysis).
- Poor symptom control.
- Malfunction/loss of a support device such as a gastrostomy tube.
- Failure of the hospice program to provide timely patient support and communication.

Management Guidelines

1. **Notify hospice** staff as soon as possible. Under the Medicare Hospice Benefit, hospice agencies are legally/financially responsible for the patient's plan of care and all medical costs related to the terminal illness. See *Fast Facts* # 82, 87, 90.
2. **Determine the trigger** for the ED visit. Pay attention not only to distressing physical signs and symptoms but also emotional and psycho-social issues. Involve social services, chaplaincy, and Palliative Care consultative services early if needs are identified.
3. **Treat distressing symptoms.** See *Fast Facts* for specific symptom treatment guidelines.
4. **If deterioration is imminent** and rapid decisions are needed regarding the use of life-sustaining treatments (e.g. intubation for respiratory failure) a focused discussion around goals of care must occur in the ED
 - Determine the legal decision maker if available and review any completed advance directives.
 - Complete a rapid goals of care discussion (see *Fast Facts* #223-227).
 - *Make recommendations.* For example, 'According to what you want for [the patient], I would/would not recommend....'
5. **If the patient is actively dying** (see *Fast Fact* #3) assess for cultural/spiritual needs; assure privacy and endeavor to identify if there are any preferred locations a patient can be safely transferred to to die (e.g. back home; to a private hospital room).
6. **Laboratory tests/diagnostics** should be limited or withheld until discussion with the patient's hospice care team. Testing should be based on patient-defined goals of care. Generally, low burden, non-invasive methods which may reveal reversible pathology or clarify prognosis should be used first.
7. **Therapeutic modalities** should be based on patient-defined goals of care rather than automatic 'ED indications' (e.g. antibiotics for pneumonia should only be used if they meet a patient or surrogate defined goal of care).
8. **Disposition** should be planned *after* discussion with hospice staff based on the patient's goals. Returning home or a direct admission to an inpatient hospice facility may be the best disposition rather than hospital admission. At times, hospices can arrange 24h professional support in the home for patients with difficult to manage symptoms who wish to remain home ('continuous care' – see *Fast Fact* #87).

9. **Notify** the inpatient palliative care service if the patient is to be admitted to the hospital. Hospice agencies may revoke a patient's enrollment in hospice care if care goals have changed, or may continue a patient under hospice care during an admission for palliation (see *Fast Fact #87*).

Summary Patient-centered care for hospice patients may be enhanced by emergency clinicians who acquire skills to quickly adapt to a supportive role in the care of a terminally-ill patient. Recognizing common triggers for the ED visit, using a multi-disciplinary approach with early involvement of hospice, social services and palliative team consults may assist in providing optimal care for ED patients under hospice care.

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**FAST FACTS AND CONCEPTS #247
INITIATING A HOSPICE REFERRAL FROM THE EMERGENCY DEPARTMENT**

Sangeeta Lamba MD, Tammie E Quest MD, David E Weissman MD

Background Patients with an end-stage illness often present to the Emergency Department (ED) with a crisis event (1). This *Fast Fact* provides information for ED providers on how to refer a patient to hospice care directly from the ED (2). *Fast Fact #246* suggests strategies for caring for patients receiving hospice care who present to the ED; *Fast Fact #298* covers Palliative Care consultation in the ED.

1. Assess Medicare Hospice Benefit eligibility (see *Fast Fact #82*). Fundamentally, this means the patient has a prognosis that is 6 months or less if his/her disease runs its expected course, and the patient's care goals are compatible with hospice (see #3 below). Broad guidelines for many cancer and non-cancer related conditions exist (3, 4, 5, 6). A useful starting point is to ask yourself, *Would I be surprised if this patient died within the next 6 months?* For disease specific prognostic information, see *Fast Facts #13, 99, 124, 125, 141, 143, 150, 189, 191, 213.*

2. Discuss hospice as a disposition plan with the patient's physician. Contact the patient's personal physician: discuss the current condition, prognosis, and prior goals of care conversations. If you are considering hospice care, ask if the physician is willing to be the following physician for hospice services.

3. Assess whether the patient's goals are consistent with hospice care. Generally this means a patient wants medical treatments and other support aimed at alleviating symptoms and maintaining quality of life, without life-prolongation. Patients may enroll in hospice care if their *preeminent* care goal is symptom relief, even if they are not entirely sure they want to completely discontinue life-prolonging therapies, as long as the hospice agency indicates they can accommodate those wishes. These four questions will help you get the discussion started to elicit if the patient and family are psychologically ready to accept hospice care (see also *Fast Facts #222-227*).

- *"What have you been told about the status of your illness and what the future holds?"*
- *"Has anyone talked to you about your prognosis; how much time you likely have?"*
- *"Are there plans for new treatments designed to help you extend your life?"*
- *"Has anyone discussed with you hospice services? What do you know about Hospice?"*

4. Introduce hospice to the patient and family/surrogates.

- Discuss the core aspects of hospice care and how these features can help the patient and family (e.g. 24/7 on-call assistance, home visits for symptom management, coordinated care with the patient's physician, emotional and chaplaincy support).
- Address concerns and clarify misconceptions.
- Phrase your recommendation for hospice care in positive language, grounded in the patient's own care goals. *"I think the best way to help you stay at home, avoid the hospital, and stay as fit as possible for whatever time you have left is to receive hospice care at your home...."*
- Discuss location of hospice care: usually this is the patient's residence such as a private home or long-term care facility. Direct admissions to hospice facilities can occur depending on bed availability and ability of local hospice agencies to arrange an immediate, direct facility admission. This is not available in all communities and requires a discussion with the hospice agency.

5. Make a referral and write orders (see *Fast Fact #139*).

Call a hospice agency; anticipate these questions:

- What is the terminal illness? Who will be the following physician? (Step 2)

- What equipment will be needed immediately (e.g. home oxygen)? Is there a caregiver at home?
- Code status (patients cannot be denied hospice enrollment if 'full code', however the hospice team will need to know if code status needs to be addressed further.)

Questions you may need to ask the hospice agency:

- *How soon can you make an intake visit to the patient's home? Can you visit the patient immediately, even in the ED (this is available in some communities)?*
- *How should I coordinate filling of new prescriptions I want the patient to have?*

Example of ED Initiated Hospice Referral Orders:

- Evaluate and Admit/Enroll in hospice care
- Terminal Diagnosis: _____.
- Expected Prognosis: Terminal illness with less than 6 month survival likely if disease runs its normal expected course [or more specific if indicated].
- Physician who will follow patient: _____.

6. Ensure patient/surrogate understanding and secure the plan. Communicate the plan following ED discharge; provide the name and contact number for the hospice agency.

7. What if hospice enrollment is appropriate, but cannot be arranged in a timely manner? If the patient can be cared for at home safely for 1-2 days without extra services, send her or him home with appropriate prescriptions and care instructions. In most communities, patients can be enrolled in hospice care within 24-48 hours, even on weekends. If they cannot be cared for safely at home, observation vs inpatient admission is likely necessary until a safe discharge plan can be established.

Summary Patient-centered care for hospice-eligible, terminally-ill patients may be enhanced by emergency clinicians who acquire skills to make early appropriate hospice referrals from the ED.

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FAST FACTS AND CONCEPTS #298
PALLIATIVE CARE CONSULTATION IN THE EMERGENCY DEPARTMENT
Sangeeta Lamba MD, MS HPEd, Tammie E Quest, MD, David E Weissman, MD

Background Adults with chronic illnesses visit the emergency department (ED) several times in their last months of life, with over half of older Americans presenting in their last month and many dying in the ED. Hence, the ED serves many patients with unmet palliative care needs. Initial care decisions made in the ED also set the future hospital trajectory of care. Early palliative care (PC) engagement in the ED has the potential to impact these decisions. In this Fast Fact we discuss the opportunities and challenges of the PC consultations in the ED.

Indications for Palliative Care consultation in the Emergency Department

- Difficult-to-manage pain or other symptoms
- Symptom management for an actively dying patient
- Rapid consensus for goals of care (e.g. intubation decision) or complex decision making
- Clarify provisions in an advance directive
- Withdrawal of non-beneficial treatments (e.g. help with terminal extubation)
- Bereavement support (e.g. after sudden deaths in victims of trauma or death of a child)
- Challenging dispositions requiring care coordination (e.g. home hospice)

Consultation Etiquette ED clinicians are charged to provide excellent and efficient patient care, with a mandate to keep patient encounters as expedient as possible. ED providers often expect in-person consultation time within 30-60 minutes. Palliative programs should proactively discuss the consultation processes with the ED leadership to clarify when and how palliative care team members will be available for an ED consult, by phone or person. To best serve the ED staff, palliative care clinicians are encouraged to follow these principles of consultation etiquette:

1. Determine the question: What is needed from the ED team? Orders for symptom control, dialogue with family, guidance with disposition planning? Certain issues, such as symptom control, may be initiated or handled over the phone whereas more complex issues such as urgent goals of care discussions may need in-person support.

2. Establish urgency: Be explicit in asking the ED team for the timeline of expectations.

- Emergent (e.g. clinical status unstable; decision to intubate, decision to withdraw ventilator)
- Urgent (e.g. patient relatively stable; help needed for disposition planning)
- Routine (e.g. patient is being admitted, has non-urgent needs, can be seen as inpatient).

3. Who is needed and when? Clarify care issues to determine which IDT member is best suited to address the ED query. Be honest about timelines for in-person support and initiate telephone support as soon as feasible.

4. Personal contact: discuss your findings and/or recommendations with the appropriate member of the ED staff before initiating any definitive patient/family communication or intervention. Recognize that this ED clinician may not be the one who initiated the palliative team consult due to shift schedules.

5. Gather additional data: To offer high quality care, the consultant will need to gather data independently.

6. Brevity: A verbal 2-4 minute summary of recommendations is useful immediately after the consult.

7. Specificity: Be explicit in disposition and treatment directions (e.g., “*begin with Morphine 5 mg IV and repeat every 15 minutes until pain is less than 5*”). Make sure your recommendations are feasible to implement and fit the ED policies and protocols. Clarify who will be contacting other stakeholders (home care, caregivers, etc) and what messages will be communicated.

8. Teach with tact: e.g. provide a *Fast Fact*, a protocol for pain, or an opioid equivalency table.

9. Provide continuity: Communicate the established plan of care to the patient, family, ED clinician and the provider for the patient's next place of disposition (e.g. the hospitalist for a patient being admitted).

10. Honor the ED environment: Appreciate the patient load and competing emergency care demands of the ED staff. Expect and anticipate shift changes and the need to orient new staff to your role and plans.

Summary Often a consult initiated in the ED does not have ample time to fully address patient needs or change immediate outcomes. PC collaboration still serves a vital role in the ED as initial discussions begun in the ED (clinician discussions about poor prognosis and introducing palliative team as part of the next steps of care) can help prepare the patient and family for future care discussions with the palliative team. PC clinicians are encouraged to learn about the ED culture and develop positive relationships by joining in ED care rounds, serving as educational resources, and working collaboratively on institutional protocols.

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FAST FACTS AND CONCEPTS #305
DEATH DISCLOSURE AND DELIVERY OF DIFFICULT NEWS IN TRAUMA
S Lamba, S Bryczowski, L Tyrie, DE Weissman, AC Mosenthal

Background: Traumatic injury is an 'out of time and out of place' event affecting people of all ages including the young and previously healthy. Disclosure of a traumatic injury or death is often performed by a clinician who has little relationship with the patient and who is compressed for time in a chaotic environment with rapidly evolving clinical factors. Mass casualties may make this even more challenging and require clinicians to manage multiple families while preserving privacy and patient integrity. Intense emotional reactions from families may range from shock to anger and clinicians must have to manage their own emotions perhaps after completing an intense and unsuccessful resuscitation. In lieu of these special considerations we describe an ABCDE framework for delivering difficult news in trauma settings. See *Fast Facts* #6, #11, and #222 for guidance on delivering bad news in general.

A: Anticipate

Who: Know the name/identity of the patient. This may be difficult as some patient's arrive in extremis as "John/Jane Doe". Ideally, have staff identify family members and their relationship to the patient prior to your arrival. In multiple casualties, it is important to ensure you are speaking to the right family about the right patient. Bring a team member who can stay longer to offer family support – chaplain, social worker, ED nurse, palliative care clinician, or bereavement specialist.

What: Know the details of: a) the event: often by police report or EMS scene descriptions; b) clinical course: extent of injuries, results of diagnostic tests and consultant opinions.

How: rehearse how you will deliver information and prepare the team. Focus on the "bottom line" and avoid getting stuck in the details. Families want to know if the patient is dead or alive, and deliver this news up front. For follow up conversations, mentally organize events into cause and effect using the "ABCs" of resuscitation e.g., there was swelling to his face so a breathing tube was placed; his lung was collapsed so we placed a chest tube; he had low blood pressure, so we gave fluids intravenously.

B: Be Aware of Self and Surroundings

Appearance: Change and remove any blood-splattered clothing/shoe covers; wear a white coat.

Location: Find a quiet room; place your cell phone/pager on vibrate.

Safety: Plan to break the news with a partner; have a safety strategy to exit the physical space in case of a violent response from family. This may mean keeping the door to the room open and unblocked when delivering news to a large group. Have security available and aware; however the presence of police or security in the room may escalate the situation.

C: Conversation/Concerns

Ask family to identify themselves and establish their relationship to the patient. Introduce yourself and your role in the patient's care and then introduce other team members.

Begin with a "warning shot" (*I'm afraid I have some bad news, or I am so sorry...*)

Concise summary of events

For patients who DIE in the trauma bay:

- Deliver news of the death *first* after a brief narrative (one sentence) that provides context that the family can understand. Recognize that there is no way to soften the impact and use the word dead/dying up front. "*Your son was in a car crash with major injuries to his heart, brain and other organs. We tried everything we could; he died a few minutes ago...*"

For patients who SURVIVE resuscitative efforts:

- Begin by outlining the most serious injury and how it will impact the patient's "big picture" condition. Meaningful information usually falls into several categories: does he have brain damage? Is he paralyzed? Will he survive? "*She has multiple injuries but we are most concerned about the serious brain damage from the injury to her head.*"
- Resist the tendency to catalog and list every injury/procedure in the initial meeting. Keep information sharing brief. Families will need time to digest the key facts.
- Anticipate next steps and prepare the family for what will happen next. Outline those injuries that will impact clinical decision making the most in the coming hours, especially

if there are associated medical interventions which will require family consent in the near future.

- Prepare family for what they will see at the bedside (e.g. splints, ventilator, wounds).

Do not speak. Allow for silence and expressions of grief, emotional or physical. Avoid giving more clinical information unless requested. Recognize diverse cultural responses to grief which may involve dramatic displays of emotion (falling on floor, wailing). As long as these do not represent a danger to staff or family, allow the space necessary for this to occur.

Empathy/Explain

- Validate emotions via verbal and nonverbal expressions of empathy
- Specify what will be happening prior to the next update as well as when and where it will occur.
- Provide an opportunity for family to see the patient. Even if injuries are disfiguring or mutilating, bereavement outcomes are improved if the family has been able to see and touch their loved one. Ensure that devastating injuries and wounds are covered prior to visitation.

D: Debrief, Document and Dictate

- Document conversation in chart using the ABCDE Outline.
- Debrief with team. Are they emotionally okay? Validate common emotions generated by death and failed attempts at resuscitation (e.g., *child, young adult, expectant mother*).
- Decide who will provide follow-up information to family and when.
- Death - Notify medical examiner and organ sharing network as per institutional protocols.

E: End the Encounter

- Engage the chaplain, social worker, Palliative Care team, or bereavement support as appropriate for the trauma team and family.
- Reflect. What went well? What did not? How could you do this better in the future?

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