PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #305
DEATH DISCLOSURE AND DELIVERY OF DIFFICULT NEWS IN TRAUMA
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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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