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The procedure for death notification — ”In Person, In Time…”

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Abstract

Informing of a patient's death is difficult for physicians as well as patient's families. Breaking bad news is part of clinical experience of physicians and existential experience of patient's close relatives. The professional manner of death notification may effectively reduce the level of stress and other negative emotions in both parties involved. Special information procedures defining cardinal rules of professional death notification have been devised to help physicians in this process. One of them, created in the United States in the 1990s, is the communication protocol — "In Person, In Time" — Recommended Procedures for Death Notification", discussed in the present paper.

Key words: patient's death, information; patient's death, physician; patient's death, family; doctor-family relationship

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One of the most difficult tasks and responsibilities of physicians is informing families of a patient death. In most cases, death in itself causes unpleasant emotional reactions, which may be additionally intensified by stress and fears associated with the necessity of delivering bad news. Generally, this responsibility lies with an attending physician or physician on duty. The available study findings indicate that emotional difficulties the physician faces while informing the family of a patient death are inversely proportional to the number of deaths witnessed in his/her practice [1]. Noteworthy, the physician's role is not confined to routine administrative activities; sometimes they have to obtain from patients the information concerning their possible organ donation refusal. Discomfort is enhanced by anxiety caused by unpredictable reactions of relatives following death notification (shock, aggression, doubts). In many cases, the pronouncement of brain death triggers lack of understanding and disbelief. The patient's body attached to sophisticated medical devices, still warm and alive a few moments ago and with the circulatory function maintained, is to be considered dead based on the information provided by the physician to the patient's family.

The proper way of informing of a patient death can effectively reduce the level of stress and intensity of shock during the first moments after bad news has been broken. For the majority of people, such moments are extremely traumatic and are likely to be remembered for the rest of their lives. Therefore, the form of notification is essential for close relatives, who affected by their loss react emotionally. The professional way of informing patients can also profoundly affect the mental status of physicians reducing their stress or fears, which is likely to strengthen successfully their sense of professionalism. The study results demonstrate that experience in informing of a patient's death can be insufficient to control fear-related reactions or in reducing the level of stress of physicians. Experience *per se* without adequate knowledge on professional measures to break this most difficult news can induce completely opposite reactions, i.e. increase the level of fear and stress with each new case when such information has to be provided. The assessment of courses dealing with skills to professionally break the news about poor prognosis or death of a patient organized for students of medicine has revealed that adequate knowledge and mastering of the communication procedure significantly enhance the sense of competence and professionalism (from 23% to 74%) [2, 3].

In the 1980s, Western medical universities recognizing the magnitude of these communication areas for patient

families, physicians as well as social reception of the level of medical services started to introduce special courses regarding skills of breaking bad news. The courses in question connect theoretical aspects (knowledge on communication protocols, clinical psychology, interpersonal and social communication) with practical aspects (skills to interpret and control the body language, express empathy, and knowledge of reactive strategies, etc.). Once acquired, the skills are perfected in accordance with the dynamics of clinical classes. Initially, students observe residents and subsequently break the news on their own supervised by the resident. In the USA, many literature reports regarding the issues in question have been published over the years. The papers analyse theoretical and practical aspects of effective breaking of bad news considering the patient's age, dynamics of death (sudden vs. expected), cause of death, social status of the family (in the aspect of those receiving the news), or even religious proveniences. The practical instructions for students and interns include characteristics of likely behaviours of relatives, appropriate forms of breaking news, possible mistakes, behaviours during the provision of information, and specific formal-administrative procedures.

Many medical communication-related strategies are available, which are to help in disclosing unfavourable news. One of those most popular in the USA is called a Six-Step Protocol for Delivering Bad News (SPIKES) designed by Robert Buckman in the early 1980s [4–6]. The protocol is addressed mainly to physicians delivering information on poor prognosis but can also be used to inform the family and relatives of a patient's death. The first widely recognized guidelines how to inform of a patient's death, called "In Person, In Time" — Recommended Procedures for Death Notification [7], were elaborated in the USA in 1992 ordered by the Office of Attorney General of Iowa and was adopted by various state services [8]. Moreover, the guidelines became the basis for designing information procedures in various medical institutions.

SPIKES is based on 5 cardinal principles, which characterize the practical way of delivering information. According to the protocol, news ought to be delivered:

1. **In person** — i.e. face to face. Notification in person forms the basis for other aspects of the procedure. Respect for privacy and for free emotional reactions is emphasized; hence, the meeting with the family should be arranged in the setting where it would not be interrupted by outsiders.
2. **In time** — information should be delivered as soon as possible provided that the notification is suitably prepared. Prior to breaking bad news, confirm the victim's identity, gather details concerning circumstances (and/or causes) of death and information (if available) regarding health of those notified, decide whether the presence of other people to support those receiving news (e.g. a priest or relatives) is needed and who should not be present at the notification.
3. **In pairs** — news should be delivered by the team of two notifiers, who support each other, are prepared for delivering news, divided their roles in the process and are ready to provide the notified person with help, if needed.
4. **In plain language** — the message should be related directly, the notifier ought to speak slowly and in single sentences, giving details and answering questions. While talking about the deceased, the use of his/her name and surname is recommended. Starting the notification some warning statement, e.g. „We have some bad news to tell you" should be used and compassion expressed ("I am sorry that this happened"). It is emphasised to avoid the reifying words (such as the body, deceased, etc.) or phases too familiar or valuating ("It is more difficult than people think…", "Most people in such a situation…", "If I were you…").
5. **With compassion** — empathy, the attempt to understand emotions accompanying individuals who are notified about death of a close relative, is essential. The protocol stresses that notifiers should avoid referring to subjective opinions and personal beliefs (e.g. religious ones "it was God's will"). Professionalism of breaking unfavourable news based on empathy assumes the readiness to support and help — the offer to contact those who can support relatives (a priest, family, friends) or accompany them during the funeral (if possible and if they want to). Moreover, it is important that the moment of informing about death was not the moment of delivering the victim's personal belongings. It should be remembered that such a message is extremely traumatic, has its own dynamics and its acceptance requires time. Therefore, some information delivered may not be understood or may be considered irrelevant. It is worthy to write down names and telephone numbers, which will be helpful in further stages of the process and during necessary procedures.

An extremely important aspect of the procedure is analysis of the process of death notification by the team delivering information. It is essential to determine what should be improved and what was successfully managed. This is also the right moment to share feelings and emotions connected with the patient or situation in which the message was delivered. A sincere conversation and mutual understanding are crucial factors reducing stress or depression.

Apart from the differences resulting from detailed and specific organizational-formal aspects of medical institutions, the entire strategy defined by the above instructions can be expressed in information protocols (analysed based on the literature gathered). Among other protocols, the

scenario of basic information for residents by K.A. Dryer [9] is noteworthy as it widens the guidelines adding rules of telephone information, emphasizing not only the necessity of delivering information but also the readiness of a physician to meet the relatives, to assist them and provide detailed information. In many cases, the message is delivered when the patient's family is at work. The protocol "In Person, in Time…." stresses to make sure (if possible) that the person receiving information by phone is in the secluded setting so the emotional reaction is not restrained by the presence of casual people. Some other protocols also include instructions how to behave when the body identification is needed (preparation and accompanying the family).

In line with the federal regulation, each hospital in the United States has its own organ procurement organisation (OPO). When the brain death is diagnosed, the attending physician or physician on duty informs only about the patient's death. The formal consent for organ donation is obtained by the coordinator (trained also in communication). The role of the attending physician or physician on duty is to provide the coordinator with information of possible consent and to encourage the relatives to give their consent [9]. Hence, the instructions in question do not consider the situation in which the physician delivering the message about patient's death asks the family for their consent for organ donation.

The preparation of communication strategies might seem doomed to failure from the start. Each situation in which the information of a patient's death is delivered is different, impossible to anticipate as to its dynamics and emotional reactions of the family. However, irrespective of complexity and individual nature of such situations, the expectations of relatives are usually the same. The physician is expected not only to carry out the medical procedures but also to informatively and emotionally support the patient's family [10]. Professionalism of the physician is assessed from this very perspective. Although no instructions or protocols can substitute for empathy of the medical personnel, they can frame certain strategies of management, which define typical, universal behaviour patterns even in untypical situations. The knowledge on appropriate forms of breaking bad news certainly makes this difficult and stressful situation more bearable for physicians.

The issues associated with death notification are practically neglected in Polish literature. It should be stressed, however, that the necessity to shape and develop soft competences by health care workers has been increasingly recognized. The importance of the quality of communication as a crucial determinant of the therapeutic process has been emphasised in some articles and empirical studies regarding the quality of therapeutic and caring services [11] or in educational programmes for medical students [10, 12, 13]. There are many publications dealing with strategies for informing of unfavourable diagnosis and poor prognosis [12, 13]. Furthermore, attempts have been made to devise suitable information procedures [14]. Nevertheless, the problem should be discussed separately as it involves such factors as patient psychosomatic status, information requirements, types of diagnosis, therapeutic possibilities, or specific determinants of cultural and social axiology.

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