International Journal of Paramedicine

Published by the National EMS Management Association (USA)

CONCEPT

BREAKING BAD NEWS IN THE PREHOSPITAL SETTING: A GUIDE FOR EMS CLINICIANS

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Recommended Citation: Zachary, T., Shelley, J., Michelle, C. (2024). Breaking bad news in the prehospital setting: A guide for EMS clinicians. *International Journal of Paramedicine*. (6), 163-170. https://doi.org/10.56068/ GLAR2701. Retrieved from https://internationaljournalofparamedicine.com/index.php/ijop/article/view/2725.

Keywords: breaking bad news, cardiac arrest, burnout, prehospital, communication, emergency medical services, EMS, paramedicine

Received: March 21, 2023
Revised: October 9, 2023
Accepted: November 13, 2023
Published: April 3, 2024

Funding: No funding provided for this project.

Disclosures: The authors report there are no competing interests to declare.

ABSTRACT

Roughly 90% of the 1,000 daily, US based prehospital cardiac arrests ultimately end in a patient's death. EMS clinicians responding to these emergencies are often tasked with breaking the bad news to families that their loved one has died. EMS clinicians report experiencing negative emotional sequalae related to these difficult conversations. EMS trends have shown increasing frequency of EMS dispatches that involve an on-sceneon-scene death. Despite the increasing frequency of this event, EMS clinicians have reported little to no training around the delivery of bad news as well as a desire to receive additional training around this subject. Formal conversation programs and curriculums do exist but have been hospital based and studied only in that setting. The prehospital environment carries unique challenges that have not been addressed by previously established conversation programs and curriculums. Our aim with this paper was to create a prehospital conversation guideline to improve both the comfort level and the skills of EMS clinicians when delivering a death notification. Our guideline was created by using established medical communication approaches with the multi-disciplinary expertise of palliative care, pediatric, emergency, and EMS clinicians with adaptations to address challenges that are specific to the prehospitall environment. The authors hope that the guide can offer a step wise approach with suggested techniques that may help EMS clinicians better navigate challenging conversations. Focused recommendations include techniques to address anger and navigating the presence of children when an on-scene death has occurred. The authors also aim to inspire, emphasize, and increase research into the very important subject of prehospital communication skills.

INTRODUCTION

Delivering a death notification is one of the most challenging and fraught parts of any health care provider's job. Roughly 1,000 cardiac arrests occur in the US daily with greater than ninety percent of prehospital cardiac arrest calls ending in death (Benjamin et al., 2019). In 2011 NAEMSP guidelines recommended that EMS agencies adopt evidence-based methodologies for the termination of non-traumatic cardiac arrest in the field (National Association of EMS Physicians, 2011). Many agencies and states such as Maine (Maine Emergency Medical Services, 2021) began implementing these protocols, likely leading to an increase in termination of prehospital cardiac arrests. A recent retrospective

review (Breyre et al.2023) of EMS calls found an increasing temporal pattern of encounters of deaths on-scene that rose from 49,802 in 2018 to 80,388 in 2021. The authors also noted in 2018, 56% of EMS clinicians responded to a call with a death on-scene, and this significantly increased to 63% in 2021 ($p<.001$). Another study of over 1,000 U.S. based EMS clinicians (Tillett et al., 2022) found that 86% of respondents reported giving a death notification within the last year. Respondents also reported receiving limited to no education around this topic, with 42% reporting never receiving any education around the subject. Greater than half of these respondents reported negative sequalae related to delivery of difficult news including intrusive thoughts, insomnia, and emotional difficulty. The overwhelming majority (96%) of EMS clinicians from this study reported that additional training around breaking bad news would be helpful.

Despite the increasing frequency of on-scene death, there is no mandated national standard or curriculum to offer guidance to EMS clinicians on death notifications. Established communication training for the delivery of difficult news exists but has been designed for care providers in the hospital and clinic settings. The prehospital setting is vastly different and poses unique challenges for EMS clinicians that are different from traditional medical settings. The need for a model of bad news delivery that addresses the unique challenges of the prehospital environment has been proposed (Campbell, 2021). To our knowledge, there is no established educational curriculum or model for communication of death notification in the EMS literature. The objective of this paper is to create a communication guide for prehospital death notification that incorporates well established communication approaches used by palliative care teams and emergency physicians.

Prehospital Guide to Making Death Notifications

Collaboration for our guide included the combined expertise of a palliative care physician, a pediatric palliative care social worker, emergency medicine physicians and EMS clinicians. We incorporated concepts developed by formal communication programs including The Serious Illness Conversation Program (SICP) and Vitaltalk adapted to the prehospital setting. The result is a stepwise approach to deliver the difficult news of a death (figure 1) in the prehospital setting. We will detail each of the steps separately, discuss navigating the presence of children, and how to deal with anger from families.

Assemble

When we deliver a death notification, it is important to assemble the 'key players', which is commonly identified to be immediate family or next of kin. However, the definition of key players can vary for each patient depending on social, religious, and cultural values. As a result, it is important to acknowledge that some patients consider other non-family individuals as key players (i.e.: clergy, non-married life partners). Key players not physically present may be included by phone. The presence of children will be addressed separately in this paper. Use the name of the deceased during conversation and ask their name if you do not know. If possible, locate the most comfortable place to gather – ideally a place that is out of public view to offer privacy and ability to sit (grass or dining room). In the ambulance is another option if no other environment is feasible. Turn down excessive noises such as radios or televisions. Be mindful of the possibility of a language barrier and need to obtain some form of interpreter such as a family

member, law enforcement, or an online application. The clinician who is delivering the news should sit or squat. Studies have shown that patients perceive providers to be more empathetic and to have spent more time during an interaction if the provider is seated (Strasser et al., 2005; Swayden et al., 2012). Given the unpredictability of a loved one's response to bad news, we recommend placing yourself in a position where you are not blocking egress from a room or space.

Understand

In having difficult conversations, the importance of listening is paramount. A dynamic conversation is crucial, where asking questions should hold equal weight to the offering of information. Ask what the key players understand has happened to their loved one. A lay person's understanding of cardiac arrest and CPR outcomes is often different than that of a medical provider. In a study of older adults, 92% stated that their knowledge of CPR came from television (Schonwetter et al., 1991). Another study observed outcomes after CPR on television and found that patients on TV had a 75% survival rate after cardiac arrest (Diem et al., 1996). Establishing what the families understand will help guide the conversation more efficiently. It will also aid you in understanding their health literacy, so you can match your delivery of information to their level of understanding.

Share

We recommend offering a 'warning shot' at the start of delivery of the news. We advise avoiding apologetic terms such as 'sorry' as this can imply blame or fault for the care provided. Instead, we suggest, "I worry that I have some terrible news about your loved one." Worry statements allow for honesty, but also a delivery with a sensitive tone (SICP, 2023). Briefly summarize the events and care provided. Avoid medical jargon and use words like "breathing tube" instead of "intubation". If you begin with announcing a death has occurred, people will often not hear anything that follows. Avoid unnecessary details (i.e.: number of shocks); instead provide a simple summary such as, "When we arrived your husband had no pulse which means his heart had stopped. We performed CPR, gave medications, and placed a breathing tube. Despite all these efforts, his heart did not start again, and he has died." We advise that the term died, or dead is used. We do not recommend euphemisms for death such as 'passed' or 'gone', as these are not universally understood and can lead to confusion. When a conversation is uncomfortable, it can be natural for some providers to fill the space with words. Allow for silence and pause to open room for the family to process what you have shared. Make a conscious effort to slow your speech and delivery down to ensure the family can process and hear what you are saying.

Close

People will react in a myriad of ways upon being notified of a loved one's death, including both physically and emotionally. Be empathetic and allow family to provide expressions of grief with you. Often all that is needed is to actively listen. A good way to respond to intense emotion is "I can see how deeply you loved him/her/they and how absolutely devastating this is for you." You can also provide non-verbal support such as offering tissues or going and getting family some water. If key players express guilt about lack of action (i.e.: not calling sooner), it is important to mitigate this with compliments such as "you did a great job calling for help so quickly" or "when we arrived, we

saw how well you were doing high quality CPR" or "you did everything we would ask a family member to do in this situation." Responding to anger will be addressed in a separate section below. Leave some time for them to ask questions. If you do not have the answer, do not speculate but instead say "I wish I could answer that for you, but I have no way of knowing that."

Delivering a Death Notification to a Child

STEP 1: Assemble
• Bring key players together (in person/phone) • Find a space for privacy and areas to sit • Clinician should be seated
STEP 2: Understand
• Ask more than tell • Identify name of the patient and use the name • Assess understanding of the significance of event • Evaluate health literacy level
STEP 3: Share
• Give a warning shot (worry statement) • Brief, simple summary of events • Use 'dead' or 'died' to describe outcome • Allow for silence
STEP 4: Close
• Allow space for grief response • Expect wide range of physical and emotional reactions • Address feelings of family guilt/regret • Leave time for questions • It is better to not know than to speculate answers

Table 1. Prehospital death notification guide summary.

Children process difficult events in a way that is vastly different from an adult and as a result require a different approach to communication. It is important to discuss with family if they would like your assistance in breaking bad news to a child such as for a death notification. It may be appropriate to delay delivery of bad news to a child depending on parental wishes or to allow the family to organize available support. Children should not be lied to and depending on the age of the child attempts to hide what has happened could be detrimental to their mental health.

Assemble

If possible, it is important to identify a trusted adult (parent/friend/caregiver) to be present and help to share difficult news with the child. Find a space that feels comfortable for the child, offer comfort items (i.e. favorite teddy bear), and sit at the child's level. Introduce yourself and your role, "Hi Sam. My name is Eric. I am a paramedic and I help people who have emergencies."

Understand

Children understand and make sense of experiences depending on their developmental ability. Identify their age and their relationship with the loved one. Children are likely

to be anxious, scared and confused. Naming their emotion can validate what the child is feeling, "It can be scary to see a loved one have an emergency." Providing positive support is duly important, "You are doing a great job being brave while our team is here." It is important to tell the child they did not cause the event, as younger children may believe they caused their loved one's emergency.

Share

Communicating the death of a loved one to a child will depend on their developmental level which can generally be understood by their age. Depending on their age, children process information through different lenses that can include both magical and literal thinking. For example, children between the ages of 3-5 years will not understand that death is permanent, so in this age group it is very important to use the terms "died" or "dead" rather than stating the loved one is sleeping, passed away, or at peace. In contrast, children between the ages of 6-10 years do understand that death is permanent and their loved one will not return. They are more likely to ask questions around the details of the death and the body. They will listen in on conversations between adults about their loved one. Children 11 years and older may ask questions about the future and how this will impact their family. They may have ideas on how they would like to say goodbye or rituals to honor their loved one. Keeping the differences of these developmental stages in mind, figure 2 will offer age specific examples on delivering death notifications to children.

Close

In times of stress or uncertainty, it is natural to speak in order to fill the silence. Be sure to allow space for the child to ask questions. Encourage the child to continue to ask questions to a trusted adult after you leave. Recognize that it is normal for a child to distract themselves with play or activities as a way of coping. Remind family that additional support resources are available to the child through their pediatrician and school.

Young Children (Ages 3-5 years)	
• Do not understand death is permanent • Avoid death euphemisms (i.e.: sleeping, passed) • Will ask the same question many times	"Grandpa's heart was very old and it stopped working. When his heart stopped working, his body died." "Mommy was in a bad accident and her body was very, very hurt. She died today." "Daddy's body is not breathing, moving, or thinking. He is dead."
School Age Children (Ages 6-10 years)	
• Understand death is permanent • May ask details about death and the body • May seek distraction to cope	"Daddy's body is not breathing, moving, or thinking. He is dead." "Grandpa's cancer made his lungs and heart not work anymore. He died."
Pre-teen and Adolescents (> 11 yrs)	
• Concern over impact on their family • May have an idea of how they want to say goodbye • Teens may be a source of support for younger children	"Mom has been ill from her diabetes. Her sugars got very high and her body became very sick. Her heart was not strong enough to keep working and her heart stopped. She died tonight."

Table 2. Pediatric age-based examples.

Dealing with Anger

Anger is not an uncommon response to stress, including the death of a loved one. Staying calm and not responding with emotion in return, albeit difficult, is vital to handling an angry person. It takes a particular self-awareness when the anger is pointed at you to not respond emotionally. For example, a loved one may scream, "If you had gotten here faster, he might not have died!" A non-defensive response such as "I can understand that you feel that if we got here faster, things may be different. We drove as fast as we could, and worked as hard as we could to help your loved one. We too wish we could have gotten their heart to beat again. I wonder if it would be helpful to walk you through all the things we did to try to help your loved one?" It is also important not to fan the flames of blame that can accompany anger. A family member may start to assign blame towards other providers such as, "If that stupid doctor would have ordered their stress test sooner, do you think they'd still be alive?" We advise avoiding playing into this and instead a response might be, "I can see how deeply your love for him/he/they is, and I can understand how hard it is for you not to think about ways this might have gone differently." Most people will calm down with standard de-escalation techniques, patience, and a little bit of time.

DISCUSSION

Delivering difficult news such as a death notification is likely becoming a more frequent task for EMS clinicians in the prehospital setting. Despite the increasing frequency of this task, education has been limited and not a standard part of the current educational curriculum. Most EMS clinicians reported having minimal or no education around this skill set (Tillett et al.2022). They also endorse negative emotional sequalae from these events (Tillett et al.2022). Just as the clinician delivering bad news can suffer, there are consequences for those receiving the news when it is perceived to be delivered poorly. This was described in the hospital setting (Ellis et al.2009), when families perceived poor delivery of difficult news by a physician, there was an increased association of psychological distress, anxiety, and depression. Although research is limited in this topic for prehospital clinicians, one study demonstrated increased confidence and competency amongst EMS clinicians after as little as 90 minutes of training on breaking bad news (Hobgood et al., 2013). This suggests that education around the delivery of difficult news may be beneficial to EMS clinicians and improve the experience of families and loved ones.

Our guideline incorporates concepts from established communication programs for medical providers (SICP, Vital Talk) with additional expertise added from palliative care providers, emergency physicians, and EMS clinicians. Research has shown that use of the SICP in the hospital and clinic settings showed improvement in many areas of provider communication (Ma et al. 2020, Paladino et al.2019) and a described positive experience for most patients (Kumar et al.2020). The Vital Talk program provides evidence-based recommendations for communication (Vital Talk 2022) and has been shown to improve the confidence and skills reported by participating physicians (Gleicher et al. 2022). Similarly, to the favorable outcomes of these hospital and clinic-based communication programs, we hope that our guideline will be of benefit for EMS clinicians who tackle difficult conversations in the prehospital setting.

Published studies surrounding communication interventions for prehospital clinicians around breaking bad news is limited. Future research efforts to examine the effectiveness and limitations of implementation of prehospital communication guidelines are needed. We hope that this paper will lead to more discussion, research, and investment in enhancing education around the very important skill of communication of difficult news for EMS clinicians. In addition to enhancing education around delivery of bad news, more research is needed to determine whether it may also mitigate the downstream psycho-social sequelae for EMS clinicians tasked with this duty. Communication skills are challenging to teach, and no script or training can consistently prepare providers for every incidence of breaking bad news, attempts must be made to further the education around this topic and to better support those who will be delivering this news.

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