An unsuccessful resuscitation: The families' and doctors' experiences of the unexpected death of a patient

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ABSTRACT

Background: The objective was to elicit families' experience of the death of a family member at the Elsies River Community Health Centre, their feelings towards the staff involved in the resuscitation and their opinions about how things could be improved. The study also elicited the doctors' experiences of communicating with the families of patients who had died in the emergency unit.

Methods: This was a qualitative study, using free attitude interviews for family members and focus group discussions for doctors. Twelve family members whose loved ones had died in the emergency room and 15 doctors who worked in the emergency room were included.

Results: Key themes were identified, relating to issues in the pre-resuscitation period, the resuscitation, breaking the bad news, after breaking the bad news and post-event sequelae. In the pre-resuscitation period, there were problems in admitting, identifying and responding to acutely ill patients. During the resuscitation, the families and staff disagreed about witnessing the resuscitation. Breaking the bad news was often difficult for the doctors and hindered by the physical environment. Afterwards, there were mixed feelings about the quality of emotional support, the use of medication and bereavement counselling. All agreed that viewing the body was helpful and funeral arrangements were not a problem. There was no effective follow-up of the families and the doctors also experienced increased stress following unsuccessful resuscitations.

Conclusion: The study found that the role of security staff should be clarified and a better triage system established to enable critically ill patients to be seen promptly. Families should be given the option of viewing the resuscitation and always be kept informed of progress. Doctors need better training in communication skills and breaking bad news, which should be done in a private area. Families should also be given the opportunity to view the body. Families should be assisted with contacting the undertaker and a follow-up visit should be organised after the initial shock, when further questions can be asked and abnormal grief reactions identified. Bereavement counselling should be available and community-based resources should be identified in this regard. Debriefing should also be available for staff involved in unsuccessful resuscitations. ***(SA Fam Pract 2004;46(8): 20-25)***

Introduction

Resuscitation training focuses on technical skills and little attention is given to breaking bad news when the resuscitation has been unsuccessful.[1] Most doctors do not really know what the needs of the grieving families are or what they expect from the staff in this time of crisis.[2] Many doctors have difficulty breaking bad news and perceive it as stressful, yet it is of paramount importance in emergency medicine.[3] When the grief reaction is inhibited in individuals or the news is conveyed in an inappropriate manner, it may have long lasting psychological effects on the family.[4,5] However, when the grieving process is facilitated, acceptance of the tragedy is better in the long term.[3,5,6] Various frameworks have been published to guide health workers in the communication skills necessary for breaking bad news.[5,7]

This study was conducted at the Elsies River Community Health Centre (CHC) in Cape Town, South Africa. The community served by the centre is of low socio-economic status and patients speak either English or Afrikaans as a first language. The majority come from either a Christian or Muslim background. The purpose of this study was to elicit the families' experience of the death of a family member at the Elsies River CHC,

their feelings towards the staff involved in the resuscitation and their opinions about how things could be improved. The study also elicited the doctors' experiences of communicating with the families of patients who had died in the emergency unit.

Methodology

A qualitative study design was used. Free attitude interviews[8] were held with 12 family members and three focus group interviews were held with 15 emergency room doctors.

Family members of 12 out of 19 patients who had died unexpectedly at Elsies River CHC between 1 June and 30 September 2001 were interviewed. Four family members could not be contacted and three did not attend the interview. Family members were contacted at least one week, but not later than one month, after the death. The option was given to conduct the interview at the family home, the CHC or a mutually agreeable venue. Interviews conducted at the CHC took place in a quiet room remote from the normal patient flow. All the family members interviewed were from the 'coloured' population, lower to middle socio-economic class and the Christian faith. The opening statement used in the free attitude interview was as follows: "Can you describe the events that occurred at the hospital on the day/night your loved one passed away? I am especially interested to know about how the hospital staff treated you and if you could comment further on anything you feel that could have been done differently."

All doctors working in the emergency unit for more than one year were invited to attend the focus group discussion. Three focus groups, comprising five doctors each, were conducted. The opening question was "What are your experiences and needs when breaking the news of the sudden death of a patient to the family and how do you deal with the stress?"

All the interviews were recorded on audiotape and video and transcribed verbatim. Topics were identified and coded inductively from the text and then grouped together into coherent categories. Data for the interviews with the families and the doctors were analysed separately. All categories were then examined to see if they could be combined into themes that did justice to the experience of the interviewees and made sense of their experience.

Table I: Family members interviewed

Interview	Age	Sex	Relation to deceased
A	33	Female	Daughter
B	40	Female	Wife
C	33	Female	Mother
D	27	Male	Father
	25	Female	Mother
E	55	Female	Mother
F	66	Female	Mother
G	29	Female	Daughter
	62	Male	Husband
H	44	Female	Niece
I	48	Female	Mother
J	52	Female	Wife
K	23	Female	Daughter
L	61	Female	Mother

Meticulous records were kept of the interviews and of each step of the analysis. In addition, the principal researcher was supervised in the analytical process by a supervisor with experience in qualitative research.

Permission was obtained from the Ethics Committee of the University of Stellenbosch to conduct the study. Written consent was obtained for the interviews with the families and the doctors. Further follow-up counselling was available for those family members who required it.

Results

Similar categories from the family interviews and focus groups were combined into themes that covered events before the resuscitation, during the resuscitation and after the resuscitation (Table II).

Pre-resuscitation issues

The families felt that too much time was wasted in admitting patients and getting them to the emergency unit. Security staff were often perceived as being unhelpful in assisting with the provision of wheelchairs or stretchers and were too strict in adhering to the rule of only allowing access to the patient and one caregiver in the case of children, but also appeared to apply these rules inconsistently. There were numerous complaints about the lack of wheelchairs and, once they were inside the centre, there was no one to sort out the emergencies from the less acute cases. Furthermore, patients were not seen unless they had a folder and acutely ill patients often had to go to reception themselves, causing a delay in initiating treatment. There were incidents of staff arguing with the patients in the waiting room and delaying emergency treatment until a folder was available.

Table I: Family members interviewed

Pre-resuscitation
Family member: "I think the parents at least should accompany the patient if it is a child. I feel very upset that I could not come in. The security I feel should be able to make exceptions."
Family member: "They could have put him on a heart machine before they sent him for a folder. My father had to walk with me to reception, as I did not know his DOB, etc. So we had to wait long for the folder as they were looking for it."
Family member: "It was a rainy day so we asked security if we could come in with the car and park closer to the entrance. She was stiff and would not fit into a wheelchair. Her father would not be able to carry her alone. They just refused and we argued for a while. They told us we just have to wait for a wheelchair and we had to reverse the car and everything."
Resuscitation
Family member: "There was no one, not a nurse, who came to comfort me. There was no support for me. In a crisis situation a few seconds feels like a very long, you hear everything, your body feels dead, and it lengthens time."
Family member: "When the doctors know that there is nothing more that they can do, then they must at least give that last 2-5 minutes for the family."
Medical officer: "I think it is wrong to let the family witness a resus. You do not know the connection they have with the patient. They don't know why you are doing what you are doing."
Breaking the bad news
Family member: "When he told me how deep the knife was, I prepared myself that he can't be alive. He broke the news well. He prepared me for it first. If he just told me he is dead, it would have been a bigger shock. He told me that they did their best."
Family member: "The doctor explained and told me of her illness. The doctor asked me if there was anything else I wanted to know. I only wanted to know what she died of."
Medical officer: "Sometimes I don't know what to do at each point for the mourning family. You feel helpless but you want to do something for them."
Medical officer: "How do you switch from that situation [resus] to seeing other patients. That is why we tend to cut it as short as possible. The less we truly get involved, the better, so that you can put it aside and carry on with your other work."
Family member: "I also don't feel happy that the news was broken in the waiting room. He should have done it in his own room. There were other patients present. He did not even call my mom to come closer."
Medical officer: "The family, I feel, must immediately be removed to a specific area and be informed. The trauma unit is not structured in this manner. People must be appointed to care for the family. It must be a pleasant room, with flowers, soft music and so on." Family member: "I do not feel bad that the sister told me [the bad news]. She did not say it in a bad way, she said it all right."
Medical officer: " I don't think the doctor should always be the one to break the bad news. If there is a sister or counsellor who has the training and the experience, they could also do it."
After breaking the bad news
Family member: "The doctor and sister were very accommodating. They gave us sugar water and showed us the body. Everyone treated us very well. Everyone was very helpful and we could stay with the body for long."
Family member: "The sister allowed us to phone the undertakers. There were no problems. The whole family could also come in."
Medical officer: "You have to be sensitive about showing the body to the family, if the guy had his head blown off. You have to warn the family."
Medical officer: "I think the night that the person dies, you need counselling more than Valium [diazepam]. The problem is, counselling is not available. This should be addressed rather than giving tranquillisers."
Medical officer: "Perhaps it is not a bad idea to appoint a priest like in the big hospitals. Why can't we get someone from the different religions in the community, and call them when there is a problem."
Post-event sequelae
Medical officer: "There must be follow up for the different stages a person goes through. That is when they need us the most. Unfortunately this is not in place."
Medical officer: "We have got to realise that doctors are human as well. I think we should work less and not more. It would help if we are trained from medical school how to break bad news, do the counselling and have the debriefing sessions. You still can't work the number of hours we do. I feel that what it does for me is that it saps my compassion. In the rest of my private life I have no compassion for anyone because my work drains it from me. You can only regain that by doing things that make you a worthy person again. You need to do that in your spare time."

Resuscitation issues

The families wanted other family members to be present and to be kept updated on progress with the resuscitation, rather than being kept in the dark. The majority would have liked to be present during the resuscitation and only a few preferred to wait outside. Some wanted to see that everything possible was done for the patient, while others were not concerned with the resuscitative procedures but only wanted to comfort and support the patient. Another important factor was spending the last few moments with the patient, especially when the prognosis was hopeless. Being present also assisted with the healing process.

In contrast to the families, most doctors felt that the family did not want to be present and that they should wait outside, as they would add to an already stressful situation. Even if the staff's skills were good, things still tended to go wrong, for example if equipment was unavailable or faulty. Some doctors felt it was wrong to show the family the resuscitation, as it is a terrible event with horrendous procedures being performed and appears disorganised. They thought that, as the rate of successful resuscitation is low, seeing the resuscitation might give the families false hope and add to their trauma. In addition, they would not know how to interpret what they were seeing and it was not practical to have someone present to explain what was being done.

Breaking the bad news

The families were generally happy with how the bad news was broken, especially if the doctor warned them beforehand that the news was going to be bad, gave good explanations and allowed them to ask questions. In a few cases it was the nurse who broke the news and the family did not mind this. However, some family members felt that the doctors were too abrupt, did not show sympathy or gave too little information. Most families wanted details about the resuscitation and the cause of death. They were not too concerned with possible mistakes made during the resuscitation, as long as they had the details.

The doctors experienced many difficulties in breaking the bad news, due to the low level of education of the families, emotional and unpredictable responses, not being comfortable with death, doubt about their own performance, not knowing the cause of death and in the case of the death of children or people with AIDS. Some tried to keep the message as short as possible while remaining available for questions. Doctors were pressurised by the knowledge that more patients were waiting to be seen and this limited the time they spent with the family and reinforced their need to not get too emotionally involved. The doctors were also uncertain whether it was appropriate for them to show emotion.

The physical structure of the emergency unit also made it difficult to counsel the family, as it was noisy, dirty, lacked privacy and was accessed by different staff who often behaved in a manner that could be deemed inappropriate.

After breaking the bad news

Families appreciated staff who gave them words of encouragement, physical contact, and medication or sugar water after the attempted resuscitation. It was useful when doctors were available for further questions and returned to the family afterwards to check on them. However, some families complained that staff was unsympathetic, unhelpful, disrespectful and more occupied with the other patients waiting to be seen. The families liked the separate area where they could spend time with the body. Most of the families had no problems with the removal of the body from the hospital premises and were grateful for assistance in contacting the undertakers.

Most doctors showed the family the body and viewed it as part of the healing process. Most of the families appreciated this, although some were disturbed if the body was mutilated. The doctors were divided as to the use of medication in the early stages of bereavement, but some advocated the use of diazepam. Others argued that counselling rather than drugs was needed, but admitted that it was often not available. The doctors felt that, with the appropriate training, other staff, such as nurses, local priests or even community members, could play a more active role in bereavement counselling. Some, however, felt that it should always be the doctor who breaks the news, as he/she leads the resuscitation, but that the counsellor could be more involved afterwards. Doctors felt that they did not get enough training at undergraduate level to deal with bereavement counselling.

Post-event sequelae

Families varied in their bereavement reactions, but in general it took time for the news to sink in and for them to accept the event. The doctors are aware that counselling is needed after the immediate impact of the bad news has sunk in, for example after two or three days.

Following a failed resuscitation, most doctors felt they needed a few moments to reflect on the event before carrying on, although others felt

that there was not enough time for this. Some preferred to keep busy and to try to forget about the resuscitation, although others struggled to concentrate. Doctors viewed the need to talk about the event as a kind of weakness. Doctors often felt bad for some time after a failed resuscitation, with feelings of worthlessness and frustration and poor sleep or flashbacks. The net effect was that it drained the doctors emotionally and affected their private lives. They needed recreation time in order to recover, but long working hours often prevented this.

Discussion

The managers of the CHC and the security company need to resolve the differing expectations of security staff. There were still a disappointingly large number of complaints concerning the unprofessional behaviour of staff and there were many transgressions of the Patient Rights Charter, which states that every patient has a right to "access to health care" and "confidentiality and privacy".[9]

Tsai found that staff usually believes that witnessing the resuscitation is harmful for the family.[10] However, patients who survived reported that they felt comforted and supported by the presence of family members. Family members felt that seeing the patient for the last time helped them with the bereavement process.[11] Tsai showed lower incidences of post-traumatic stress disorder and prolonged grief in those witnessing the resuscitation and found that between 67% and 75% of family members would like to do so. Interference by family members was uncommon in most studies. Medico-legal conflict normally occurs as a result of poor communication and allowing the family to witness the resuscitation may decrease litigation.[10]

Dubin and Sarnoff recommend that the doctor should never delegate the task of informing the family.[4] The doctors in this study debated whether they should always be the ones to break the news, while the families were indifferent on this matter. The emergency room is not the ideal place to break the news and everyone expressed the need for a specific room to perform this sensitive task. In addition, there still seems to be a need for more training of doctors in breaking bad news.

Families needed time to absorb the shock and it was of little use to give too much information. The importance of allowing the family time for "shut down" is also emphasised by Silverman et al.[7] and Ptacek and Eberhardt.[3] The difficulty lies in the timing of when the doctor is ready to give information, which is usually at the time of breaking the news, and when the family wants to ask questions, which is usually some time later.

Families preferred doctors who seemed to care and showed emotion, whereas the doctors felt that it was unprofessional to show emotion.[12] Dubin and Sarnoff recommend that the doctor should encourage the family to express their feelings and that tranquillisers should be avoided, except in extreme cases.[4] Doctors in this study individualised the use of medication, but felt it could not replace effective counselling. The viewing of the body facilitated the grief reaction and the family should be given the opportunity to view the body, even if it is mutilated.[1,13]

Follow up of the family was neglected, yet it is an important part of the process.[3,4,5] The family, including those not present at the time of death, should have at least one follow-up visit to assess their response and to deal with further questions. They should be educated regarding the symptoms of the grief response and reassured that they are normal. Arrangements should be made for a family member or friend to support the survivors for the next 24 to 48 hours. In view of the lack of staff and huge workload in the emergency unit, it may be a good idea to involve community counsellors in the process.

Doctors were often not comfortable speaking about their own stress and a critical incident debriefing session might help them to work through the experience, vent their frustrations and start thinking about solutions to improve conditions.[14]

Interviews with the family were all conducted at the CHC, which may have inhibited them from freely expressing any negative feelings. A further weakness of the study was that all the families were Christian. Families of other faiths may have had different viewpoints to those expressed in the study.

Conclusion

This study explored the perceptions of families and doctors who experienced unsuccessful resuscitations at the Elsies River CHC. The study found that the role of security staff should be clarified and a better triage system established to enable critically ill patients to be seen promptly. Families should be given the option of viewing the resuscitation and should always be kept informed of the progress. Doctors need better training in communication skills and breaking bad news. The bad news should always be conveyed in a private area. Families should also be given the opportunity to view the body.

After the event, the families should be assisted with contacting the undertaker and a follow-up visit should be organised for after the initial shock has passed, when further questions can be asked and abnormal grief reactions can be identified. Bereavement counselling should be available and community-based resources must be identified in this regard. Debriefing should also be available for staff involved in unsuccessful resuscitations.

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