

Palliative Care Interest Group

Palliative Care Series: Coping with Death in the Emergency Department

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It is never an easy task. To walk into a room and inform a family member that their loved one has died is a daunting responsibility that we face daily in the emergency department. For many of us it has become second nature, a procedure similar to that of placing a chest tube or intubating a patient. There are steps that we take to ensure that the procedure goes well. We introduce ourselves, perhaps ask a

question about what the patient was doing prior to the event that led to his or her death. The news is then delivered that the patient died despite our efforts. Another pause follows and time is allowed for any unanswered questions and eventually we leave the room. The family is left to begin their time of grieving and often times, we the care providers, neglect our own thoughts and feelings about what just transpired and move on to the next patient. Between the adrenaline rush and the mental focus many of us feel both depleted of energy and defeated because the battle was lost to “save” that patient’s life.

Many cases resonate with us in some way. For a brief period we are provided with a glimpse of a patient’s life and what that individual meant to his/her family. Pediatric cases are viewed as more difficult because of the patient’s age. Care providers who are parents themselves may project and think about their own child/children. In some instances the individual may have initially presented to the emergency department in a stable state but rapidly declined and succumbed to an unexpected death. As care providers it is essential that we establish a process when faced with the death of a patient. This process is an essential component of self-care and maintaining resilience in our field. Without it burnout looms and eventually those negative feelings take hold and remain. Sarcasm builds, cynicism and many other negative thoughts and feelings then define how we practice. This all eventually culminates into grief and compassion fatigue. We subsequently pass this on to the next generation of physicians, our residents who view the lack of “process” as the appropriate approach to death in the emergency department.

Information about the “process” is lacking in its focus on emergency medicine physicians. The literature primarily discusses the loss of a pediatric patient and its effect on health care professionals. Additional findings include a variety of articles about compassion fatigue amongst the nursing staff or resident physicians and their ability to cope with death in the emergency department. More research is needed in this setting with the primary focus on the attending physician’s ability to cope with death.

In the field of emergency medicine we are tasked with the leadership role. We initiate resuscitative efforts and are expected to have a calm and focused approach by our team. We may be overlooked as participants in the debriefing process often due to this expectation. Many of us believe that we should be able to “function” despite our chaotic work environments and the traumatic cases we face each day without attachment or reflection. Debriefing in health care is a format to facilitate discussion of actions and thought processes, encourage reflection, and ultimately assimilate improved behaviors into practice.² It can be used to determine ways in which team performance can be improved or as a time of reflection for all care providers involved. All should be encouraged to participate and share their feelings regarding the traumatic event. Debriefing should include a friendly atmosphere, open-ended questions, honest dialogue, and identification of behaviors or perceptions that led to improved outcomes.¹ Some may fear that one’s job will be comprised and as a result decline participation. It is of utmost importance that confidentiality is stressed and upheld during this process in an effort to build trust for current and future sessions. The discussion should be led by facilitator, favorably one who is unbiased and trained in the process of debriefing. One proposed model is the The CISD (Critical Incident Stress Debriefing) tool. This provides structure and serves as a guide for how the discussion should be held.

1. Introduction: Ground rules are stated and the role of the facilitator is defined
2. Facts: A brief overview of the events that occurred is stated
3. Thoughts: what was each participant thinking at the time of the event?
4. Reaction: What was it about this event that bothered participants most and why?
5. Symptoms: The evolution of feelings since the event occurred (immediate and delayed).
6. Teaching: Normalize the symptoms brought up and provide stress management information
7. Reentry: Closure of the meeting. Provide an opportunity to ask questions as well as additional resources for those who need more support.⁵

Debriefing may not be feasible in some circumstances. The practice of mindfulness has become a more popular concept. The foundation of mindfulness is to center oneself, to be present and use the innate knowledge and wisdom to address any stressful event. It can be also be viewed as a way of “pressing the reset button” before re-entering the chaos of the shift. This involves slowing your breathing, calming your mind and emotions in an effort to perform at your most optimal state. With repetition a stable foundation can be established and allow for appropriate processing when dealing with patient death in the emergency department. ●

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