

# Paramedic delivery of bad news: a novel dilemma during the COVID-19 crisis

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## ABSTRACT

As a result of the COVID-19 global pandemic, paramedics in the UK face unprecedented challenges in the care of acutely unwell patients and their family members. This article will describe and discuss a new ethical dilemma faced by clinicians in the out-of-hospital environment during this time, namely the delivery of bad news to family members who are required to remain at home and self-isolate while the critically unwell patient is transported to hospital. I will discuss some failings of current practice and reflect on some of the ethical and practical challenges confronting paramedics in these circumstances. I conclude by making three recommendations: first, that dedicated pastoral outreach teams ought to be set up during pandemics to assist family members of patients transported to hospital; second, I offer a framework for how bad news can be delivered during a lockdown in a less damaging way; and finally, that a new model of bad news delivery more suited for unplanned, time-pressured care should be developed.

## INTRODUCTION

Paramedics are used to working in less than ideal circumstances, problem solving and generally doing a little bit of everything in the realm of unplanned care. One part of the role is breaking bad news to relatives. In normal circumstances this task arises as part of a decision to terminate a resuscitation, or in recognising life extinct in patients for whom resuscitation would have no benefit. Although difficult, and arguably a task for which we have not received adequate training, paramedics have developed an implicit set of techniques for breaking bad news in a sensitive way. During these situations we usually have enough time to sit with families<sup>1</sup> and explain what has happened, drink a cup of tea and, on occasion, sit and listen to stories of their loved one's life. Although time consuming and emotionally challenging, this allows us to support the family and guide them gently through what practical steps come next when dealing with loss of someone in the UK. By contrast, rarely if ever do paramedics inform a family of an imminent unexpected death. Although a multiskilled profession, we are still an emergency service. When a patient is critically unwell we will tell their family to prepare for the worst, but that we are trying everything we can to prevent death. We work quickly and take the patient and family members to hospital. This ensures that the patient has the best chance of survival through receiving definitive treatment, while at the same

time allowing the family to be involved in the care and the patient journey. Although they will be somewhat prepared for the possibility of death through statements warning of a potential negative outcome, a real conversation about this is left to our colleagues at hospital. In the hospital environment when survival is unlikely the family get the chance to say goodbye and trained staff are on hand for pastoral care.

The current pandemic has upended the situation for paramedics, hospital staff, patients and their families. Infectious disease control policies instituted in response to COVID-19 have meant that visitors were no longer allowed in hospital, resulting in patients dying without seeing their families. There have been numerous cases of people saying goodbye to their loved ones via video call. Under the strictest phase of the government-mandated lockdown, funeral homes were also no longer allowing visits or viewings, and funeral numbers were severely limited due to social distancing. Although at time of writing these restrictions have either been lifted or greatly reduced, the condition remains volatile and there is a very real prospect that similar restrictions will come back into force in the future. This has meant for some that the last time a family will see their loved one is as they are being carried out of their house by paramedics. Many out-of-hospital staff recognised this issue and started informing families of the risk of not seeing the patient again and started allowing them a few moments to say goodbye, all the while reassuring them that the only chance of survival is for immediate hospital care. This is a complicated situation, as the need to give family members time to interact with their loved one must be balanced against the need to carry out assessment, treatment and transportation of the patient in a speedy manner in order to maximise the patient's chance of survival. It is also a difficult scenario to prognosticate, as with such a new and strange disease, making a prediction on outcomes in the out-of-hospital environment with limited diagnostic tools is very difficult.

We have therefore gone from a situation where breaking bad news for paramedics was almost entirely the act of death notification to this new situation where we are instead notifying the family of a potentially terminal diagnosis. As death notification is not time pressured we have become used to setting a scene where we can be supportive clinicians, breaking bad news in a relaxed manner. This is a stark contrast to us dealing with a critically unwell patient and the speed with which we must move. We have therefore found ourselves delivering news we are unused to handling, while rushing through the process due to the needs of our patient.

<sup>1</sup>For clarity, the term 'family' or 'family member' is used, however this is meant with the recognition that family more broadly means 'loved ones' and does not have to entail blood relation or marriage.



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## CHALLENGES AND CONSIDERATIONS IN OUT-OF-HOSPITAL BAD NEWS DELIVERY

There is very limited evidence concerning best practice around breaking bad news in the out-of-hospital environment, although some models have been suggested in the case of out-of-hospital cardiac arrest.<sup>12</sup> Generally, there is agreement that paramedics do not receive adequate training in breaking bad news.<sup>2,3</sup> Paramedic education around breaking bad news differs greatly depending on which institute it is taught in and it is often limited to a single lecture without any practical elements. In a small study of semistructured interviews with paramedics it was highlighted that clinicians primarily learnt how to break bad news through observing others, leading to a wide variety of skills and styles of breaking bad news and a general feeling of discomfort with the practice.<sup>3</sup> This feeling of discomfort is not unique to the paramedic profession; similar findings have been observed in studies of doctors and medical students.<sup>4</sup> When doctors and medical students get specific training, this helps build their confidence in the act of breaking bad news and assists both the clinician and family member to have better outcomes from the experience.<sup>4</sup> Therefore, similar considerations ought to apply to paramedics.

### Importance for the clinician

The act of breaking bad news can have serious effects on the clinician, with it being cited as a reason for clinician burnout.<sup>5,6</sup> Some clinicians feel the protection they have from the emotional reality of their work slips in these moments. As one paramedic interviewed in the Mains and West<sup>3</sup> study said, it *'pulls you from back out of the clinical and into the human'*. These are the times when we are no longer just the professional doing our job but are a part of an intensely human and emotionally resonant scenario. This, especially with the added stressors of working within a global pandemic, shows that there is a need for training in breaking bad news to both build personal resilience in the clinician and provide a standardised quality of care.

### Importance to the patient

Having bad news broken in the wrong way decreases acceptance of the news, increases levels of both post-traumatic stress disorder (PTSD) and depression and gives people a poorer feeling of satisfaction from their healthcare interactions.<sup>4</sup> There are many ways in which bad news can be broken poorly. The news can be delivered in a rushed manner, without first setting the scene, without sitting the family member down, without giving them full attention, appearing distracted, not allowing time for questions, or by being too blunt and lacking empathy.

Feeling involved with their loved one's treatment is also an important part of helping families accept bad news. For example, it is well documented that families wish to be a part of the resuscitation process when a patient is in cardiac arrest.<sup>7,8</sup> It has been shown that having them involved in this way helps them come to terms with the death of their loved one and helps reduce levels of PTSD and depression from the event.<sup>7</sup> Resuscitation can be viewed as a journey rather than simply the act of cardiopulmonary resuscitation<sup>ii</sup> and involving the families through each step can improve their satisfaction<sup>9</sup> and the mental health implications from the sudden loss of their loved ones.<sup>10</sup> This is something which is being denied to our patients' families during the COVID-19 crisis due to the understandable requirement for

people to isolate when living with someone symptomatic and the limitations on hospital visitors. Considering that during the COVID-19 pandemic families are losing the opportunity to be a present part of their loved one's healthcare journey, and that they are in a position where the bad news they have received will have been broken to them in a less-than-ideal manner, we must consider the implications of our interactions with these families and how best to navigate our way through them.

### Issues with the current models

The current models of breaking bad news are not designed for use in the emergency out-of-hospital environment. The seminal 'SPIKES'<sup>iii</sup> protocol,<sup>11</sup> for example, becomes unworkable in the first section, 'S—setting', with the authors recommending that the clinician has prepared themselves for what they plan to inform the receiver of the news, manages time constraints and sits the person receiving the news down taking the time to make a connection. Obviously, while having a time-sensitive transfer of a critically unwell patient, this is not possible as the time constraints are always ever present, and it is rare that the clinician truly has time to prepare. Similarly, the rest of the model encounters issues regarding time constraints making it unsuitable for the hyperacute setting. This is understandable as it was a model designed for use in oncology, a very different clinical setting. Another model which has previously been proposed is called the 'ABCDE'<sup>iv</sup> approach.<sup>12</sup> This model is similar to the SPIKES protocol in that it is not appropriate in these time-sensitive scenarios as the emphasis is on setting the scene and allowing space for a real conversation to be had between the clinician and person hearing the news. Parts of both of these models are used by out-of-hospital clinicians in time-pressured scenarios, however the speed at which these conversations must take place means the real utility of the tools has been lost. The model suggested by Brown,<sup>v</sup> specifically for paramedic use, is only intended to be used during a cardiac arrest, in order to facilitate family-witnessed resuscitation, and is therefore limited in its utility. However, with the Brown model there is at least recognition of the possibility of the clinician breaking news in a time-critical scenario and suggestions of supportive acts one can take in the case of an out-of-hospital resuscitation. Still, this model is not fully applicable in the scenario described within the circumstances that exist during a pandemic with a lockdown. Currently, there seems to be no suggested model for this manner of bad news delivery and little to none for the out-of-hospital environment. This means there will be no standardisation of care, leaving the planning and modes of delivery up to the individual practitioner. This has the potential to lead to avoidable harm.

<sup>iii</sup>SPIKES is a six-step protocol for breaking bad news delivery; the mnemonic is: S—setting; P—assessing the patient's perception; I—obtaining the patient's invitation; K—giving knowledge and information to the patient; E—addressing the patients' emotions; S—strategy and summary.

<sup>iv</sup>ABCDE—Advance preparation; Build a therapeutic environment/relationship; Communicate well; Deal with patient and family reactions; Encourage and validate emotions.

<sup>v</sup>The Brown model suggests actions during resuscitation: (1) *On arrival*: Introduce yourself. Gain a brief history. Stress need to treat immediately. Promise an update; (2) *Soon after resuscitation attempt established*: Advise relatives of the situation. Invite the family in if not already present. Summarise treatment; (3) *Further into resuscitation*: Advise of possible outcomes. Allow questions; (4) *Recognition of life extinct (ROLE)*: Invite the family to be present for termination. Tell them when death is recorded.

<sup>ii</sup>An example of the resuscitation journey being: treatment in the out-of-hospital environment; being transported to the emergency department; being treated in ICU or surgical intervention; recovery on ward; discharge; and rehabilitation.

## THE DILEMMA

The patient–clinician relationship extends to the patients' families. Although the medical needs of the critically unwell patient must be prioritised, the effects of interactions with families cannot be forgotten. We should consider our interactions with family members to be a clinical relationship in itself and therefore be aiming to do no harm, or at least minimise the harm done through our interactions with them. To take away the patient without informing the family that this could be the last time they see them denies them the chance to have one last moment and slips into a paternalistic model of care. However, by informing them of this risk in a hurried manner and then leaving, telling them they have to isolate for the community's sake and wait for a phone call from the hospital for more information, goes against current advice regarding breaking bad news and has the potential to traumatise the family member. We are faced with the prospect of leaving the family, or in some cases an individual, alone in their house with the advice to self-isolate, leaving them with limited or no access to real pastoral care or to the traditional informal support networks which exist within communities.<sup>vi</sup>

This is both a moral and a practical dilemma. It seems that a balance needs to be found between allowing the families to be informed and accidentally traumatising them through doing this the wrong way. It is important that we try to mitigate a potential mental health crisis from our interactions. We therefore need a rethink on what we can offer our patients' families who are being left behind in these circumstances.

## RECOMMENDATIONS

In the light of the above, I present three recommendations for improving the breaking of bad news in the out-of-hospital environment.

### Pastoral support outreach teams

First, pastoral support should be offered to the families of patients who are being taken under emergency conditions to hospital. We should start to consider these people as patients themselves and have a dedicated team to call, or visit, in order to offer them a similar package of support as they would have received had they been in hospital or with a palliative care team. This should be a proactive move by the National Health Service, with the support of charitable organisations if required. As to whether this team is a part of social services, the ambulance service or the hospital is a question for policymakers. However, having the knowledge that these people will be followed up with some real assistance and guidance will mitigate the potential negative outcomes for the families and will allow the clinicians who are transporting the patients some peace of mind, knowing that the person they have left alone will get some level of support.

### Proposed framework for breaking bad news during lockdown

As described thus far, breaking bad news in a hurry and then leaving the receiver of the news alone and isolated will never be an ideal scenario. We can however work to mitigate the negative effects of this. In order to do this a framework is required to help standardise care, learn what works and develop and change accordingly. A potential framework can be seen in [box 1](#).

<sup>vi</sup>In the case that the individual being left alone is elderly or vulnerable, we make an emergency referral to social services, although vitally important for immediate care needs this does not really provide any pastoral support, nor is this a suitable option for most of our patients.

## Box 1 Framework for breaking bad news during lockdown

**Recognise**—early recognition that the patient will likely require critical transfer and hospitalisation.

**Assess**—fast assessment of which family members live there; if there are any obvious extra care needs; get a brief overview of the living situation.

**Inform**—explain that their loved one is critically unwell, share your working diagnosis, use language that the listener will understand—for this step it is best to give warning shots (through simple introductory sentences) to lessen the shock.

**Questions and concerns**—ensure the listener has a brief time to ask questions, address them as best you can with the given time restraints, respond to any emotion given with empathetic responses.

**Reassure**—reassure the family member that hospital treatment is the best chance for a full recovery while ensuring they are aware of the seriousness of the situation.

**Refer**—the family member must be then referred to a specialist team immediately on handing the patient over at hospital, a self-referral number should also be available for the family to call for more information if required before the formal referral is made.

Patients should be encouraged to reach out to their own informal networks via telephone.

Empathetic communication must be used to minimise harm and the clinician must appear to be present for the receiver of the news despite their haste. The initial two steps of this framework should be done while making the initial assessment and diagnosis of the patient. The following three steps require the full attention of one of the clinicians attending. Although not always easily done in the out-of-hospital environment, this should be possible in most cases. Due to the speed of these situations there will inevitably be more questions and more support required for the family member once the attending crew has left, therefore the final step is arguably the most important. A referral to a specialist pastoral support outreach team must be made without delay by the ambulance crew.

### New model for breaking bad news in the acute setting

This pandemic has highlighted the existing issue of bad news delivery by paramedics. A new, more general model for breaking bad news in the acute setting ought to be developed. This should be proposed by paramedics but have input from psychologists and other specialists in order to create a realistic model that works for the clinicians using it as well as one that is responsive to the needs of the people receiving the news. Multidisciplinary training ought to happen across the spectrum of unplanned care clinicians so that each of us is aware of what happens in each specialty and the manner of news delivery and pastoral care can become somewhat standardised.

The situation we have right now in which clinicians are having to work with best guess, rather than best practice, is potentially damaging to both the general public and the clinicians. It is imperative that these issues are at the very least discussed before the next serious outbreak of infectious disease so that preparations are in place and we can alleviate a potential far-reaching mental health crisis in society and maintain public trust in our health services.

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