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Paper:

Maunder, E. & Maguire, D. (2017). Breaking bad news:the need for a coping mechanism in paramedicine.
International Paramedic Practice, 7(1), 3-7.

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Title Page:

The Emotional Challenges of Breaking Bad News in the Paramedic Role: The Paramedic MANAGED Breaking Bad News Tool

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Abstract

Paramedics face breaking bad news as part of their role and are placed in emotionally challenging clinical situations without warning. The term ‘breaking bad news’ does not do justice to what paramedics are expected to deliver. The extreme environments paramedics find themselves in at short notice, and often without warning, requires skilful communication. Put simply, it is not ‘bad news’ they are called on to break, it is devastating, life changing and catastrophic. Paramedics must maintain professional composure and deliver information to already traumatised relatives or significant others, with the casualty or patient on the scene. It has been found to be one of the most emotional parts of the paramedic role (Soto and Cooke 2013). There is need to consider a strategic approach to support paramedics in dealing with giving bad news for their own emotional well-being, as well as the emotional well-being of those they serve. This paper explores ways to help the paramedic deliver bad news. It considers coping strategies to help paramedics proactively support themselves with this necessary part of their work.

Key words: Paramedic, breaking bad news, emotion, support

Key Points

Breaking bad news is skilled work

The Paramedic MANAGED Breaking Bad News Tool takes into account the unpredictability and immediacy of the paramedic role

Debriefings should be an integrated part of the paramedic role

There is benefit for having a National Strategy for Breaking Bad News for paramedics

Introduction

In his role as National Ambulance Director, Peter Bradley states in the foreword of the National End of Life Care Programme for Ambulance Services (Association of Ambulance Chief Executives 2012) that ambulance services are crucial in the delivery of high quality care at end of life. Step 1 of the Pathway outlined in the Programme states the need for ‘open, honest communication’ as end of life approaches. The 6 steps of the Pathway follows the care that ought to be provided for dying patients/relatives who are able to have time to consider advanced care planning. It includes need for good organisation and coordination of service provision, and access to specialist palliative care and post bereavement support. For the ambulance services, the main focus in the Pathway is on “rapid discharge home to die”, and this focus makes sense if patients are known to be near end of life. This is not the situation paramedics face, all too often, where people die without planning, without time to prepare and where there is no expectancy that death will occur. For such patients and their families, the End of Life Care Pathway (2012) is simply not appropriate.

“Paramedics ...must transition from resuscitators to death notifiers in a matter of moments...this can be very challenging” (Soto and Cooke 2013).

From a paramedic perspective, Iserson (2011) emphasizes that paramedics need to mentally prepare themselves to cope with this part of their role, and to recognise their own anxieties and feelings relating to this. It is neither clever nor helpful to deny the need for structured emotional support for those delivering frontline services. The paramedic role is unpredictable. It is not known at the start of a shift what will be faced during the working day. It would be impossible to emotionally prepare for all eventualities, but what can be prepared for is the likelihood that at some point during the day there will be a requirement to break bad news. Different people have different coping strategies. Developing strategies that

are known to work on both an individual and team level can be a tremendous advantage to people working in emotionally challenging roles (Maunder 2008). This paper seeks to offer a structured protocol for breaking bad news. It offers mechanisms that guard against emotional degradation.

Main body:

From a medical perspective, "bad news" has been defined as any information which adversely and seriously affects an individual's view of his or her future (Baile et al 2000).

From a paramedic perspective, the degree of impact on a person's present situation for the worse can be extreme. They are required to inform people that someone who is significant to them has died at the scene. Paramedics have to be sensitive that there may be a gap between what the person understands to be the situation and the reality of what is really happening.

The London Ambulance Service (Dom 2011) has been proactive in offering guidance to paramedics for breaking bad news. It is clear in stating that when it is done incompetently it can make a situation worse. It reinforces the need for empathetic listening and truthful conversation, conveyed sensitively and at a pace that is appropriate to the survivor's response to the information. Dom (2011) states:

“As an integral part of our duties, breaking bad news is a sensitive and important matter because it maintains trust, reduces uncertainty, prevents inappropriate hope, allows for adjustment, and it prevents a conspiracy of silence”

The London Ambulance Service (Dom 2011) cite Kayes (1996) model '10 Steps in Breaking Bad News' as being useful prompts for delivering bad news. It was originally written from a medical perspective for doctors breaking bad news to patients with terminal medical conditions (see table 1)

Table 1: Peter Kaye's 10 Steps to Breaking Bad News

1. **Preparation:** be factual with clear objectives in a private setting.
2. **What does the person know?:** ask for a narrative of events; “How did it all start?”
3. **Is more information wanted?:** “Would you like me to explain a bit more?”
4. **Give a warning shot:** “I’m afraid it looks rather serious” and allow the person to respond.
5. **Allow denial:** denial is a defence and a way of coping. Allow the patient to control the amount of information.
6. **Explain:** narrow the information gap. Detail will not be remembered but the way you explain will.
7. **Listen to concerns:** what are your main concerns at the moment? Allow space and time for a response.
8. **Encourage ventilation of feelings:** this allows for empathy.
9. **Summary and plan:** summarise concerns, refer on, give closure.
10. **Offer availability:** offer further explanation, include other healthcare agencies, support groups and family support.

Much of the literature about ‘breaking bad news’ and many of the models offering guidance related to this has been written from the perspective of doctors and nurses, and in particular from the perspective of oncologists breaking news that a patient has cancer. For example, Kaye’s (1996) model offers excellent prompts to encourage professionals involved in giving bad news to consider the patient’s feelings in the process of receiving such news. Similarly, Baile et al (2000) developed a six-step protocol known as SPIKES (see table 2) aimed at helping doctors deliver bad news to patients facing the diagnosis of cancer.

Table 2. SPIKES Model (Baile, Buckman, Lenzi et al 2000)

Setting up the interview:
Assessing the patient's Perception
Obtaining the patient's Invitation, as shunning information is a valid psychological mechanism. Obtain permission to share information
Giving Knowledge and information to the patient
Addressing the patient's Emotions with Empathetic response
Having a Strategy and Summarising refer on to other professionals and answer questions

As part of the protocol, doctors are advised to set up an interview with the patient to break the news in person, ask that they may like to bring with them a trusted friend or relative, ensure that protected time is set aside to have opportunity to give time to the patient when breaking the news, provides guidance on avoiding jargon and using appropriate language, and suggests information on how to pace the conversation to enable the patient to take in the enormity of the news they are receiving, offering time to ask questions which should be answered honestly and sensitively, concluding the consultation by summarising the conversation and offering factual information on what happens next. Yet both models leave the paramedic vulnerable as they, for the most part, do not have the opportunity to plan ahead to prepare patients for receiving bad news as recommended in Kaye's (1996) and Baile's (2000) models.

Yet another widely used tool for breaking bad news is Narayanan , Bista & Koshy's model (2010). Narayanan et al (2010) offers a 6 step protocol, abbreviated to BREAKS, for systematically breaking bad news to ensure that key issues relating to the information given are not missed.

Table 3: BREAKS Model (Narayana, Bista & Koshy 2010)

B ackground – knowing the patient
R apport – demonstrating unconditional positive regard
E xploring – ascertain patient knowledge
A nnounce –provide warning shot then give information in straightforward terms
K indling – checking understanding and providing space for emotions
S ummarise – respond to concerns and information on next steps

Again written from a medical perspective, it is intended to give confidence that the news has been given sensitively. Narayanan et al's (2010) model (see model 3) stresses the need to prepare well beforehand by obtaining "in-depth knowledge of the patient's disease status, his emotional status, coping skills, educational level and support system" (Narayanan et al, 2010, p.1076)

This is clearly not possible in the immediacy of the situations paramedics face. Unlike doctors preparing for consultation, paramedics find themselves with patients and survivors suddenly facing death or receiving news that their relative or significant other has died. Breaking bad news is skilled work. From a paramedic perspective, it would be impossible to have a one size fits all approach with a script of what to say that can be rehearsed or memorised ahead of the event. People's responses to such events are very individual and no two situations are ever the same. What is known is that breaking bad news can be "extremely stressful for the...professional involved" (National Council for Hospice and Specialist Palliative Care Services 2003, p.5), and especially so when there is a personal connection with those receiving the information (Maunder 2008).

It is difficult to find academic evidence of the impact of breaking bad news on the emotional well-being of paramedics. We were unable to find research to support this, although there is anecdotal evidence in various social media and news articles where paramedics describe this part of their job taking a toll on their health (Kirk 2015). From a paramedic perspective, Iserson (2011) states that paramedics report this area of their work to be the most emotionally difficult part of their job, and that there is need for more education needed to help them with this part of their role. The Welsh Ambulance Service (2016) has been proactive in recognising that there is need to support the health of their workforce and has put in place opportunities for health promotion aimed at reducing sickness levels. Stress is identified as a major cause of ill health, but it is not directly linked to any one aspect of the paramedic role. There is clearly a gap in knowledge here. The mental health charity MIND launched the Blue Light Programme in 2015 recognising that, from their online survey of emergency staff and volunteers that 87% reported having experienced poor mental health at some point (MIND 2015). They clearly recommend mental health support for all working in emergency services in England and Wales and put forward recommended ten actions aimed at achieving this. Included in the ten actions is the need for proactive commitment to improving staff wellbeing at strategic level, with designated staff support systems. Statistics relating to the well-being of paramedics speak for themselves. In England, figures for the NHS sickness absence rates for paramedics in the first quarter of 2015 showed a sickness rate of 6.78%, the highest sickness absence of all health professionals (NHS Digital 2015). A year later, although the figure had fallen slightly, Ambulance Trusts continued to have the highest average sickness absence rates of all health care professionals with an average of 5.79% (Health & Social Care Information Centre 2016) . In Wales, the Welsh Ambulance Services NHS Trust has the highest sickness absence of all health professionals in Wales, with a sickness absence of 7.8% recorded in the period 2015-16 (Welsh Government Statistics 2016); and in Scotland, figures

released on the 31st August 2016 reported a sickness rate of 7.57%, second only to the State Hospital sickness rate of 8.4% in the period April 2015 – 2016 (Information Services Division (2016).

The Welsh Ambulance Services NHS Trust (WAST) are not alone in recognising that overall sickness absence is related to stress. Their three-year Integrated Medium Term Plan (2016) sets our clear goals for the quality of the service delivered. It stresses the need for paramedics to feel valued in their role, offering “immediate access to telephone counselling...with opportunity for face to face counselling if required...posters and leaflets...signposting staff to resources for advice” (WAST 2016, p. 119), with possibility to receive health promotion activities from a dedicated Trust Health and Well-being Steering Group. This implies that to receive such support is an additional service offered, and is reliant on the paramedic actively seeking the support as opposed to it being a costed and integrated part of the role itself. It is noted that within the plan there is no specific reference to help front line staff deliver bad news.

Section 8 of the Health and Care Professions Council’s (HPC) Standards of Proficiency for Paramedics (2014) provides recommendations for establishing protocols for information and support to be given to patients. It states the need for effective communication using language that is clearly understood. It stresses the need for appropriate verbal and non-verbal skills in communicating information, and the need to modify communication to the service user’s level of understanding. It is again noticeable that there is no reference to the particular communication skills required for giving bad news despite this being such an important part of the paramedic’s work, although it is noted that interpersonal skills and communication is a key element of the HPC education programmes in Higher Education Institutions in the UK.

The National Institute for Clinical Excellence (NICE) guidelines for Major Trauma: Service Delivery (NICE 2016) includes recommendations for establishing information and support protocols to be given to patients, and survivors at the scene. It does not specify what should be included when breaking bad news, but offers information on some of the support groups available to help people deal with the consequences of major trauma.

There is benefit for having a paramedic tool for breaking bad news that takes into account the unpredictability and immediacy of the paramedic role, and the challenging environments in which paramedics are placed when delivering such news. We offer the following paramedic model for breaking bad news, abbreviated to MANAGED for ease of use. This has been developed as a result of listening to paramedic students and emergency medical technicians undertaking paramedic education at Swansea University. Many of the latter have worked in the field for many years, and they repeatedly stated they felt ill prepared to deal with this part of their work. All stated they had received no formal training in this prior to their course. We have created this model specifically aimed at addressing the key concerns identified by the students in class and in consultation with experienced paramedic colleagues working in the field.

Table 4: MANAGED Paramedic Breaking Bad News Tool

- M – Mentally setting up and prepare
- A - Able and confident practice
- N- Notice survivor response and assess understanding of what has occurred
- A – Accurately and sensitively give information and knowledge
- G – Give time for survivor’s response – hear their story
- E – Attend to survivor’s Emotions and signpost to support before Exiting the scene
- D - Debrief

Mentally setting up and prepare

Proactively get as prepared as possible that during the day breaking bad news will be required. Mentally adjust for the role. This should be as routine as with all other areas of preparation are at the start of a working shift, and includes being organised to deliver bad news. Regional Ambulance Trust protocols include use of a leaflet that paramedics must give out stating what happens in the event of sudden death, with guidance on procedures that will be followed for managing sudden death, including information on being contacted by the Police, and Coroner requirements. Know the regional protocol for sudden death.

“It is true that no protocol can anticipate every eventuality; every notification will differ in some way...It can however, help notifyers prepare for their task and help them” (Iseron 2000 p 2)

Ensure that the leaflets are available and know where they are kept in the Ambulance. Such information should be available in different languages if these are the languages used in the local area. There is benefit in knowing the area and the communities served.

Ensure that there is familiarity with all of the equipment and consumables in the Ambulance. Make sure that nothing is out of place.

Able and confident practice

From a paramedic perspective, Iseron (2011) describes the need to master delivery of care, including resuscitation, with the person in mind. Persons are those witnessing the attempts to save life at the scene. Even when there is little hope of survival, if persons see that all efforts were made to save the casualty or that the care was delivered expertly, calmly and confidently, that in itself can be a comfort to those witnessing paramedic attendance.

Be realistic in the care provided. Guidance from the Resuscitation Council (2016) is clear:

“If the healthcare team is as certain as it can be that a person is dying as an inevitable result of...a catastrophic health event, and CPR would not re-start the heart and breathing for a sustained period, CPR should not be attempted” (Resuscitation Council 2016, p.4).

Yet for some persons they are further traumatised if they believe nothing is being done to save their loved one – the key skill for the paramedic at this point is to ensure that they are communicating that not attempting CPR does not mean they are not providing care. Ensure that persons know care is appropriate and includes, for example, excellent pain relief.

Notice survivor response and assess understanding of what has occurred

Actively listen to what the person is saying or asking. Observe if persons appear to have understood the enormity of what has just occurred. The questions they ask can provide information of their understanding. Although factual and unambiguous information will be required, there is benefit in repeating the words used in their questions gently back to them before stating factually what has happened, if the words they use are appropriate. This can facilitate their coming to terms with taking in the information, and also provides very first information at the relative's level, using a language that they use and understand.

As an example, if the relative uses the words ‘he has passed away?’ it would be sensitive to say gently ‘yes he has passed away...pause...he has died’

This is not to be confused as replacing the need for factual information, simply the gentle starting point leading to truthful and factual knowledge. Remember the way the words are said, and the words that you use, are so important, and cannot be underestimated. Using the

language used to you where possible can help convey information that is understood by those receiving the information, and that, for example, irrespective of own religious or spiritual views views or lack of religious views, if the person has comfort from thinking their relative or significant other is in heaven then simply nod and agree.

Soto and Cooke (2013) state:

“Survivors may not be able to remember specific details related to an event that may be lasting for paramedics, but can and do remember in remarkable detail, the exact words they heard, feelings they felt and images they witnessed at the time they learned of the death of a loved one”.

Similarly:

“The way the news is broken can stay in the memory of survivors for the rest of their lives. The exact words used, the tone of voice and the expression on the face of the person who delivered the news” (Meoli 1993).

This is where compassion, sensitivity and empathy shown towards persons is really needed and valued

Accurately and sensitively give information and knowledge

Be factual and truthful and clear, mindful that the way information is conveyed is as important as what is said. Ensure the survivor is in no doubt that their relative or significant other has died. Be sensitive always. If it is possible, add that the patient was not conscious, or that pain or anxiety was alleviated quickly, or anything else relevant to that particular situation that can help make the news more bearable to hear. Be honest, stay calm, and quietly give the information in a caring manner.

Give time for person's response and hear their story

Show that you care. Listen. It can help the survivors cope with the enormity of what has just happened if they are simply able to give their story and know that they are being heard. This also provides opportunity to obtain more information on events leading up to the call out for Ambulance support.

Attend to person's emotions and signpost to support before exiting the scene

Respect the person's grief, and if possible offer a private area or screen the person from the public to maintain his or her dignity in grief until further help, such as professional support or another family member is called or arrives.

Professionally deal with the practicalities associated with that particular situation.

Signpost the person to further support and help, as appropriate, by giving the information leaflet detailing the regional protocol of what happens next in the event of sudden death, ideally written sensitively in their first language.

In addition, verbally inform the person of what will happen next.

Ensure that the person is supported by a significant other if possible before leaving the scene.

Debrief

Straight after leaving the scene try and make opportunity to complete the following Personal Debrief Prompt:

Personal Debrief Prompt

What went well?	e.g. you kept the situation calm
What could have gone better?	e.g. traffic or environmental factors
Are there issues here we need to remember for future situations?	e.g. moving a consumable to an easier place to locate in the ambulance
Have I learnt something from this experience?	Pertinent to that particular experience/situation

The Personal Debrief Prompts will be useful for team debriefings if paramedics feel able and choose to share them.

Debriefings should be costed as a crucial part of the paramedic role. They provide the option for paramedics to talk about their work with others who understand the role and include opportunity to:

- Explore the critical events leading to the situation,
- Discuss the challenges and constraints to attending to the casualty relating to environment or other aspects relating to a situation,
- Consider what went well, and what could have gone better
- Compare, and share learning from experience.

Debriefings provide opportunity to give and receive feedback of own performance with peers, and learn from experienced mentors (Iserson 2000 p. 261)

From a pragmatic viewpoint, this may not be done on the day events occur, but all members of a team should know that there will be opportunity at some point in a working week where team members will be able to touch base for such debriefings.

One criticism to such a suggestion may be that paramedic teams work shifts, and that it would be impossible to get all members of a team together at any one time. The challenge is to work around that, and consider offering debriefing meetings when there is cover for those attending by another team – the point being that the groups attending the debriefings have opportunity to meet together regularly for such emotional support, and that this is seen as part of their work.

To conclude, the HCPC's standards of proficiency for paramedics (2014) state the need for paramedics to:

“recognise the need to engage in critical incident debriefing, reflection and review.....[and] understand the importance of maintaining their own health”

(Iserson 2000) describes breaking bad news as “emotionally draining” and that those

“receiving the news can easily tell which notifiers care and which are only going through the motions” (Iserson 2000 p. 261).

There is need for recognition that witnessing and attending to traumatic dying and death is at the very least harrowing, and although it is true that some people cope by simply getting on with the job, it is unrealistic to expect that when people ‘switch into their role’ they completely ‘switch off their emotion’ –we may deal with situations when we are experienced and trained and educated to do so , but over time , and without adequate support, that wall of emotional protection can crack, and when cracks occur, then burnout seeps in.

It is obvious that there is need for adequate staffing levels to provide best practice. That, in itself, can be a coping strategy to help deal with this challenging part of the job. When paramedics know they have done all that they could have done, have had time to break bad news to the standard, were able to provide the support to the survivors who witnessed their

care, then they have peace of mind and are able to function more effectively in their role.

There is clearly need for a national strategy for breaking bad news for paramedics, including the provision of adequate structured emotional support for paramedics to maintain their own well-being in order to do so.

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