Nurses as Death Notifiers: a Report from Nurses in Iran

Nematullah Shomoossi[1*], Mostafa Rad[2], Mohsen Kooshan[3], Javad Ganjloo[3]

[1.] Department of English, Faculty of Medicine, Sabzevar University of Medical Sciences, Sabzevar, Iran
[2.] PhD Candidate, Department of Nursing, Faculty of Nursing and Midwifery, Sabzevar University of Medical Sciences, Sabzevar, Iran
[3.] Department of Nursing, Faculty of Nursing and Midwifery, Sabzevar University of Medical Sciences, Sabzevar, Iran
Correspondence author: nshomoossi@yahoo.com

Abstract: Background and Purpose: Breaking bad news, particularly death notifications, is among the hardest tasks of a medical team. Therefore, the present study was intended to investigate delivering death notifications to survivors from the perspectives of nurses in Iran. **Methods and Materials:** This descriptive analytical study was conducted 97 (29 male and 68 female) nurses in Iran, who completed a questionnaire including demographic information, questions on their training and familiarity with SPIKE or ABCDE strategies, as well as 25 Likert questions based on ABCDE strategies. The obtained data were analyzed in SPSS using descriptive statistics and correlation coefficients. **Results:** The results indicated that most nurses had witnessed death victims but they reported no formal training for death notifications and helping survivors to control their emotions. Also, the participants were *unfamiliar* with SPIKE (99%) or ABCDE (88%) strategies. Also, most of the participants agreed with adopting the ABCDE strategies in delivering death notifications. **Conclusion:** The results indicated an urgent need for training nurses on communication skills to deliver death notifications, with special attention to the emotions and reactions of the survivors.
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1. Introduction

Death is a painful socio-cultural reality and the last stage in one's life. People often avoid talking about death since it is associated with emotions such as fear, fury and grief. Thinking about one's own death or encountering the death of a loved one is a difficult and disheartening task too (Nordstrom et al., 2011). In case of end-stage patients, the patient and the kinsmen have enough time to prepare themselves for accepting the forthcoming death; equally, the attending physician and the medical team members may not encounter a hard task to inform them of a threatening fact. In such cases, talks may arise about autopsy, donations, and other legal issues. However, the patients expect the medical team to provide them with an honest notification (Ausman, 2006). In medical emergency cases, patients find themselves helpless, and their significant others, kinsmen and relatives need to be notified about the treatment and progress of medical procedures; consequently, the death notification can be unexpectedly disappointing with emotional consequences (Nordstrom et al., 2011). However, in traumatic cases (such as accidents) or heart attacks, the chances of preparing for a successful death notification may be low; accordingly, unpredictable emotions and reactions from the survivors and significant others will be more likely. In some cases, the broken heart syndrome may occur, which is a temporary heart condition brought on by stressful situations, such as the death of a loved one. People with broken heart syndrome may experience sudden chest pain or feel a menacing heart attack. The condition was originally called *takotsubo* cardiomyopathy, also referred to as stress cardiomyopathy, stress-induced cardiomyopathy or apical ballooning syndrome; affecting women more than men, the syndrome is treatable, and the condition usually reverses itself in about a week (Steliosa et al., 2010).

Studies show that death notification without prior training and preparation takes practitioners to emotional embarrassment, with negative outcomes for survivors. Other studies show that patients, significant others and survivors of victims wish to be provided with an outspoken, but sympathetically-stated, death notification (Ausman, 2006). Their satisfaction and inclination to accept the death notification cannot be achieved without nurses' prior training in communication skills (Nordstrom et al., 2011), and the cooperation of nurses and doctors (Wakefield et al., 2003).

The importance of death notifications has also led to the development of some strategies. For instance, ABCDE mnemonic is suggested by some oncologists, which stands for five expressions *Advanced preparation, Build a therapeutic*

environment/relationship, Communicate well, Deal with patient and family reaction, and Encourage and validate emotion (Rabow & McPhee, 1999); also, SPIKE is an acronym for the words *Setting, Perception, Invitation, Knowledge, and Empathy* (Baile et al. 2000). Therefore, the issue requires a tactfully planned protocol on how to successfully deliver the notification; members of the team to do the task must be trained and the ultimate member to finally deliver the message should be clearly assigned. Currently, *nurses* are placed in a dubious position in Iran to deliver the notification, often unprepared and untrained. However, conventional nursing education hardly ever concerns this issue, and little is known to be included in syllabi and curricula; consequently, preparation to perform is such situations needs to be included in nursing education (Minichiello et al., 2007).

To sum up, breaking bad news, particularly death notifications, is a difficult task for a nurse as a member of the medical team. However, it is not adequately treated in nursing education literature. Preparation and training protocols are, therefore, required to be integrated into nursing curricula, with special attention to the feelings and reactions of the survivors. In line with earlier studies, the present study is intended to investigate delivering death notifications to survivors from the perspectives of nurses in Iran.

2. Methods and Materials

This descriptive analytical study was conducted in three major hospitals in Sabzevar, Iran. Ninety seven (29 male and 68 female) nurses with various work experiences and educational levels participated in the study, and completed a questionnaire including demographic information (age, gender and education), seven multiple-choice questions on their being trained to break bad news and familiarity with SPIKE or ABCDE strategies, as well as 25 Likert-type questions based on ABCDE strategies.

The questionnaire was developed according to the ABCDE strategies and a review of related literature. Also, it was reviewed and rephrased by the authors and colleagues. As for content validity, it was validated by test-retest and internal validity coefficients. The final draft of the questionnaire was given to the participants; they were all provided information regarding the aims of the study and how to complete the questionnaire. They were ensured that their personal information and ideas would be kept confidential, and that the results will be published as research article containing no personal information. The completed questionnaires were coded and analyzed in SPSS using descriptive statistics and correlation coefficients.

3. Results

A summative look at the results indicated that 97 nurses including 29 men (29.9%) and 68 women (70.1%), with a mean age of 30.1±6.17 years ranging from 21 to 50 years participated in the study. Mean employment history was 6.68±5.12 years; as for their education, 10 nurses had high school diplomas (10.3%), 2 associate degrees (2.1%), 83 bachelor's (85.6%) and 2 MSNs (2.1%).

The results indicated that 83 nurses (85.4%) had witnessed many death victims in their career; however, 69 nurses (71.1%) reported no formal training for death notifications or helping survivors manage their emotions; the rest reported acquiring skills by experience (28.9%). Although a great majority of the participants were *unfamiliar* with SPIKE (99%) or ABCDE (88%) strategies, almost all of them did break bad news (including death notifications) to survivors in the past years. Based on clinical experiences, 43 nurses (43.3%) evaluated their own performance as death notifiers to be *good*; others evaluated them as either *average* (45.4%) or *bad* (11.3%). As part of the questionnaire (Questions 8 to 32) was developed on the basis of ABCDE mnemonic, the results, presented below, were also grouped around the five major strategies as follows:

4. Advanced preparation

The eight questions associated with the *Advanced Preparation* (or A) strategy were as follows(Table 1):

Table 1: Questions related to Strategy A (Advanced Preparation)

NO	QUESTIONS
8	I choose an isolated and quiet environment to break death news.
10	I prepare myself emotionally to break death news.
11	I review my preparation in mind before giving death news to patients' significant others.
12	I practice outloud how to give the death news.
13	I take a note of words and expressions to use when giving death news.
14	In case of less experience, I observe an experienced colleague's practice, or do some role-play with him/her.
29	I consider my own needs on how to give the death news.
30	I consider the challenges and after-effects of giving death news.

How the participants answered the questions above is summarized below:

Table 2: Distribution of Answers to Strategy A Questions (Advanced Preparation)

Strategy	Disagree		No idea		Agree	
	Number	Percent	Number	Percent	Number	Percent
Advanced Preparation	15.37	17.9	22.87	23.58	54.25	58.73

In other words, 58.73% of the participants agreed that they needed a quiet environment, emotional preparation, outloud practice, taking notes of words and expressions, observing an experienced colleague's practice, or doing some role-play, attention to one's needs and considering challenges in breaking a bad news. Participants who disagreed with theses strategies were significantly fewer (17.9%) (Table 2).

4.1. Build a therapeutic environment/relationship (Strategy B)

The second group of five questions was developed on the basis of B-strategy (i.e. Building a Therapeutic Environment/Relationship) (Table 3):

Table 3: Questions related to Strategy B (Building a Therapeutic Environment/ Relationship)

NO	QUESTIONS
9	I do emphasize clinical information and medical facts when braking bad news.
15	I introduce myself when giving bad news.
16	I take into account the reactions of the patients' significant others.
17	I evaluate the knowledge and understanding of the patients' significant others about his/her condition.
18	I evaluate the tolerance of the bad news in patients' significant others.

The participants' answers to B-strategy questions are summarized in Table 4 below:

Table 4: Distribution of Answers to Strategy B Questions (Building a Therapeutic Environment/Relationship)

Strategy	Disagree		No idea		Agree	
	Number	Percent	Number	Percent	Number	Percent
Building a Therapeutic Environment / Relationship	11	11.52	15.6	16.9	69.8	71.36

In other words, 71.365% of the participants believed in emphasizing clinical information and medical facts, introducing oneself, noting the reactions of the patients' significant others, evaluating their knowledge and understanding, as well as their tolerance of the bad news when braking bad news. Far fewer participants did not report doing these strategies (11.52%) (Table 4).

4.2. *Communicate effectively (Strategy C)*

The third group of questions related to the strategy C (i.e. Communicate effectively) included five questions as stated below (Table 5):

Table 5: Questions related to Strategy C (Communicate effectively)

NO	QUESTIONS
19	I am clear and outspoken but my words are sympathetic.
20	I use medical terms when giving bad news.
21	I prepare a background (e.g. by saying *I am afraid, I have a bad news for you*).
22	I tell the patients' significant others, "we did our best."
32	I communicate effectively and successfully when braking bad news.

The participants' answers to the C-strategy questions are summarized below:

Table 6: Distribution of Answers to Strategy C Questions (Communicate effectively)

Strategy	Disagree		No idea		Agree	
	Number	Percent	Number	Percent	Number	Percent
Communicate effectively	27.4	28.24	13.8	14.22	56.8	57.52

As indicated above, 57.52% of the participants were clear and outspoken but sympathetic, use less medical terms, prepared the background, and communicated effectively and successfully when braking bad news. The performance of 27.45 of the participants was opposite, and communicated less successfully (Table 6).

4.3. Deal with patient and family reaction (Strategy D)

The fourth group of (D-strategy) questions included three questions as follows (Table 7):

Table 7: Questions related to Strategy D (Deal with patient and family reaction)

NO	QUESTIONS
23	I let the patients' significant others either keep silent or cry.
24	I allocate enough time to answer questions of a patient's kinsmen around.
25	I respond to a patient's kinsmen's emotional reactions (such as denial, blame, depression, etc).

The participants' answers to the D-strategy questions are presented in Table 8 below:

Table 8: Distribution of Answers to Strategy D Questions (Deal with patient and family reaction)

Strategy	Disagree		No idea		Agree	
	Number	Percent	Number	Percent	Number	Percent
Deal with patient and family reactions	9.4	8.6	15	15.2	75.6	76.2

It was observed that 76.2% of the participants stressed the importance of dealing with patient and family reaction by letting the patients' significant others either keep silent or cry, allocating enough time to answer questions of a patient's kinsmen around, and responding to a patient's kinsmen's emotional reactions (such as denial, blame, depression, etc). number of participants disagreeing the items was less in comparison (8.6%) (Table 8).

4.4. Encourage and validate emotion (Strategy E)

The fifth group of (E-strategy) questions included four questions as follows (Table 9):

Table 9: Questions related to Strategy E (Encourage and validate emotions)

NO	QUESTIONS
26	I sympathize with a dead person's significant others.
27	I tap the person on the shoulder, if needed, after giving the bad news.
28	I confirm/approve of the person's feelings when they express their feelings.
31	I use tactile/touch where necessary.

The participants' answers to the E-strategy questions (i.e. Encourage and validate emotions) are presented in Table below:

Table 10: Distribution of Answers to Strategy E Questions (Encourage and validate emotions)

Strategy	Disagree		No idea		Agree	
	Number	Percent	Number	Percent	Number	Percent
Encourage and validate emotions	12.25	12.64	24.25	24.97	60.5	62.45

In other words, 62.45% o the participants sympathized with a dead person's significant others, tapped the person on the shoulder, used tactile/touch where necessary, and approved of the person's feelings when they express their feelings. Participants doing otherwise were 12.64% (Table 10).

Table 11: Distribution of answers to the ABCDE strategies

Strategy	Items	Frequency	Strongly agree	agree	No idea	Disagree	Strongly disagree
Advanced Preparation	8	Percent	9.51	49.22	23.58	15.72	2.18
		Number	6.5	47.75	22.87	15.25	2.12
Building a Therapeutic Environment/ Relationship	5	Percent	13.82	57.54	16.9	9.68	1.84
		Number	13.4	56.2	15.6	9.4	1.6
Communicate effectively	5	Percent	9.3	48.22	14.22	23.92	4.32
		Number	9	46.8	13.8	23.2	4.2
Deal with patient and family reactions	3	Percent	18.56	59.46	15.5	5.83	0.7
		Number	18	57.66	15	5.66	0.677
Encourage and validate emotions	4	Percent	9.78	52.57	24.97	11.87	0.77
		Number	9.5	51	24.25	11.5	0.75

5. Discussion

The present study was conducted to investigate delivering death notifications to survivors from the perspective of nurses in Iran. The results indicated that most nurses had witnessed death victims but they reported no formal training for death notifications or helping survivors to control their emotions. Also, the participants were *unfamiliar* with SPIKE (99%) strategies or ABCDE (88%) mnemonic. As for the ABCDE strategies, it was observed that most of the participants agreed with adopting these strategies in delivering death notifications (i.e. *Advanced preparation, Build a therapeutic environment /relationship, Communicate well, Deal with patient and family reaction, and Encourage and validate emotion*) (See Table 11).

Below, we will discuss the results in relation with other studies, based on a three-stage educational model of death notification (Stewart et al., 2000); Stewart and colleagues (2000) surveyed 254 death notifiers and suggested that the procedure of death notification can follow three stages: (1) specific details on how to deliver death notification, (2) how to manage survivor reactions, and (3) how to manage their own emotional reactions.

6. How to Deliver Death Notification

In the present study, most nurses reported no formal training for death notifications and helping

survivors to control their emotions. In a non-Iranian context, Stewart and colleagues (2000) also found that nearly 40% of respondents had received neither classroom nor experiential training in death notification, although 70% of respondents had performed at least one notification. This can be considered as an emphasis on the role of training. In order to train death notifiers, Nordstrom and colleagues (2011), implemented the *role-play exercise* on fourth-year clerkship students, who considered it as highly relevant in preparing them for delivering death notifications; also, 97.4% of the participants found it as a training opportunity for developing communication skills. Much earlier, Mullins and Merriam (1984) examined the effects of a two-day training program on nursing home nurses and their responses to the dying patient, and observed a significant increase in the nurses' knowledge about death and dying, and a significant decrease in the death anxiety among the nurses. Other studies show that the survivors often wish to be provided with an outspoken, but sympathetically-stated, death notification (e.g. Ausman, 2006).

Educational programs can improve students' experience, confidence and competence of death notification (Smith-Cumberland & Feldman, 2006; Hobgood et al., 2009). The use of strategies such as ABCDE mnemonic (*Advanced preparation, Build a therapeutic environment/relationship, Communicate effectively, Deal with patient and family reaction, and Encourage and validate emotion*) (Rabow & McPhee, 1999) can be useful too. Studies show that death notification without prior training and preparation takes practitioners to emotional embarrassment, with negative outcomes for survivors. In general, training programs can lead to substantial enhancement of skills in death notifications (Stewart et al., 2000).

7. Managing Survivor Reactions

The reactions of human beings to death notifications depend on circumstances, personal beliefs and cultural effects. However, sadness, anger, frustration, relief, and guilt may be observed in survivors. Lack of notifier training can lead to unpredictable reactions from the survivors; for example, (a) attempts to harm themselves or others (b) physical acting-out, and (c) intense anxiety were among severe survivor reactions which were the most difficult for notifiers to manage during the notification (Stewart et al., 2000).

Most survivors appear confused at the initial notification; others may feel abandoned after the notification. Some individuals may request assistance from counselors for funeral arrangements. It is recommended that imposing personal religious beliefs is not helpful and could be harmful; statements such as, “This was God’s will,” “She led a full life,” and “I understand what you are going through,” may not demonstrate compassion or regard for the survivors' grief experiences. However, it may be important for a nurse to gather information regarding religious beliefs and customs in order to guide the survivors to their religious leaders, if applicable (Jackson-Cherry, 2009). In any case, the notifiers are expected to consider the reactions of the survivors as part of the notification process.

8. Managing Notifiers' Own Emotional Reactions

Stewart (1999) contends that death notification puts a toll on the informer performing the task, with long-term effects on the grief process of survivors. Notifiers may become distressed during notification in cases of (a) violent crime, (b) drunk driving crashes, (c) suicide, and (d) the death of a child (Stewart et al., 2000). Whereas overemotional counselors can increase confusion and possible panic with survivors, it is better for a counselor to express appropriate emotion than to appear cold and unfeeling (Jackson-Cherry, 2009). Additionally, death notifications can be stressful and emotionally draining to those involved in giving death notifications and it is important to discuss feelings or thoughts associated with the death notifications that may have triggered personal unresolved grief. Jackson-Cherry (2009) recommends taking care of oneself when taking care of another person’s initial grief. Without appropriate training, counselors report feeling helpless and powerless in this process (Ender & Hermsen, 1996); this can lead to professional burnout and job stress.

9. Conclusion

Nurses are in the front line of the caregiving and treatment; consequently, the survivors and significant others feel comfortable to ask them for the final news of their patients. In other words, it is the nature of nursing to deliver death notifications on the one hand, and help survivors control their emotions on the other. The process can put a toll on the informer performing the task, with long-term effects on the grief process of survivors (Stewart, 1999). To achieve success in managing both duties, two major things seem to be necessary: training and strategic performance. Educational programs and training are found to enhance communication skills, as reported for instance, by Nordstrom and colleagues (2011). Baghcheghi and colleagues (2011) also suggested cooperative learning and applying active teaching methods for improving communication skills of nursing students especially in interactive skills. However, Nordstrom and colleagues (2011) believe that little effort has been made to embed notification of death within the undergraduate medical education curriculum. Therefore, issues of communication can

be integrated into the nursing education curricula (Minichiello, et al. 2007).

Future research can dwell on *who should act as death notifiers* or *is it the duty of a team or even a different individual*. Developing team works and investigating the death notification in practice can be investigated in experimental and qualitative studies. The consequences for the nurse's future career and life can also be considered in future research. The reactions and feelings of the survivors and the notifiers can be the focus of studies in other investigations too.

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