Following best practice can help to facilitate normal grieving for bereaved relatives

Breaking news of death to relatives

In this article...

- How, when and where to tell relatives about a death, and who should tell them
- Honesty, sensitivity and ethics on breaking news of a death
- Advice on support, respect and privacy

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Abstract


Breaking news of death can have a significant impact on bereaved relatives if it is not carried out appropriately. This article explores best practice on breaking news of death, and discusses why it is so important for nurses to get it right.

Breaking news of death to relatives is a frequently performed task for nurses, and one of the most stressful and sensitive they are asked to take on.

Using best practice guidelines to break news of death (see Box 1) can help prevent relatives enduring complicated grieving processes.

This article explores how news of death should be communicated, including where and when it should be delivered, and who should be the bearer of the news. It discusses the nurse’s role in this process.

Because there has been a surprising lack of recent research on this subject, literature from the past 30 years has been used.

Breaking news of death

When patients die, their medical practitioner has a duty of care to their next of kin and relatives (Buckman, 1992).

Communicating the news of a patient’s death to a relative can be likened to breaking bad news to a patient with a terminal diagnosis. However, although both are covered by the umbrella term “breaking bad news”, the finality of death means communicating the news of a terminal illness and news of death have significant differences.

The initial communication of the death of a loved one is the first step in the bereavement process. To facilitate a normal grieving process, it is essential that relatives receive excellent communication and support from healthcare professionals. The way in which news is given will always be remembered by the bereaved, whether delivered well or not (Harrahill, 2005; McCulloch, 2004).

Who should communicate news of death?

Doctors have the legal authority to certify death (General Medical Council, 2009), so it is normally the medical practitioner in charge of a patient’s care who informs relatives of the death (Buckman, 1992).

However, this practice was criticised by Wright (1996), who said the doctor communicating the news of death would usually be a complete stranger to the relatives. At this vulnerable time, it would be better if they received the news from an individual with whom they had established some sort of relationship and rapport, usually a member of the nursing staff.

Wright (1996) suggested this issue could be addressed by doctors continuing to break the news, but always accompanied by a nurse to provide support for the family; this nurse should be known to the family where possible.

Jurkovich et al (2000) investigated which elements of delivering bad news were most important to relatives. A survey tool was designed and administered to family members who had lost a relative in the accident and emergency department or the trauma intensive care unit over an 18-month period. The final sample included 54 interviews with relatives in relation to the deaths of 48 patients.

The authors found 81% of participants were informed of the death of their relative by a doctor, with only 5% being informed by a nurse. Fewer than half (46%) of participants felt the seniority of the news giver was of medium or high importance.

Faulkner (1998) said the responsibility of breaking bad news should rest with the person the recipient would feel most comfortable with. Lomas et al (2004) supported this, suggesting the person receiving the bad news should know the medical professional communicating it.

How and when should news of death be communicated?

Buckman (1992) created a six-step protocol for breaking bad news (see Box 2). This is based primarily on Buckman’s experiences of breaking bad news in a clinical setting, and was originally created for breaking bad news to patients. The protocol can be adapted, however, to provide nurses with a structured, organised approach to communicating with relatives.

The term patient is used in the original protocol but is interchangeable with the term relative, which has been used for the purposes of this article.

Step 1

Buckman (1992) stressed the need for face-to-face interaction between the doctor and...
**BOX 1. BEST PRACTICE IN BREAKING NEWS OF DEATH**

**Who?**
- A doctor and nurse who are familiar with the relatives and who have provided care for the patient.

**Where?**
- A private, non-clinical area, which can be used by the relatives for as long as they need. This needs to be a spacious room with adequate seating where interruptions will be kept to a minimum.

**How and when?**
- Where possible, death should be anticipated and relatives encouraged to spend time with the patient before death occurs.
- Face-to-face communication with relatives is preferable to a telephone conversation.
- Consider body language. Medical professionals are advised to sit when breaking bad news and maintain eye contact.
- Assess the relatives’ existing knowledge before breaking the news.
- Information should be honest and accurate, tailored to meet the relatives’ needs and shared in an empathetic and caring way.
- Avoid euphemisms. Words such as “dead” and “died” should be used and repeated several times.
- Respond appropriately to relatives’ reactions and give them time to ask questions. All questions should be answered.
- Prepare the relatives for dealing with practical matters, such as collecting the death certificate.
- If the relative is not present when the patient dies, they should be contacted by telephone and encouraged to attend the hospital. However, if they ask if their relative is alive or dead, they must be told the truth.

**BOX 2. SIX-STEP PROTOCOL FOR BREAKING BAD NEWS**

1. **Step 1** Get the physical context of the conversation correct. Avoid breaking the news over the telephone where possible.

2. **Step 2** Assess how much the relatives already know about the patient’s situation.

3. **Step 3** Find out how much the relatives want to know. It will be enough for some to simply know that their loved one is dead; others may wish to know the events that led to death in detail.

4. **Step 4** Provide information. This should include a diagnosis where possible, the treatment that was given before death, and an offer of support.

5. **Step 5** Respond to relatives’ feelings. This involves using good listening skills and having an awareness of non-verbal communication.

6. **Step 6** Prepare the relatives for what is expected of them after they leave the deceased, including advising them on practical matters surrounding the death.

Source: Buckman (1992)

**5 key points**

1. **Breaking news of death is one of the most stressful and sensitive tasks that a nurse will have to perform**

2. **The amount of information about the death wanted by relatives will vary**

3. **Information must be given clearly, and euphemisms such as “passed away” avoided**

4. **Staff who avoid telling the truth on the telephone, and ask the family to come to the hospital, may lose the family’s trust when they find out the death occurred before they were contacted**

5. **Relatives should be advised on practical matters after a death, such as registering it and organising a funeral**

The recipient of the bad news. Nurses can play a crucial role in this, particularly if they are the professional contacting the relatives. By inviting the relatives onto the hospital ward to speak with the doctor, nurses can avoid the difficult situation of breaking bad news over the telephone.

**Step 2**

According to Harrahill (2005), before the news is broken to relatives, it is good practice for nurses to assess their existing knowledge of the situation.

This provides a good understanding of exactly what information needs to be communicated. It also allows a quick assessment of the family’s style of language, enabling staff to adapt their communication style and use the most suitable vocabulary.

Nurses can facilitate this with statements such as: “I am aware you may have spoken to a number of my colleagues. Tell me what you already know and I’ll try to avoid repeating what they may have previously told you.”

**Step 3**

Harrahill (1997) said the person breaking news of death should tailor the information to the relatives’ needs and answer their questions.

It will be enough for some relatives to simply know that their loved one is dead; others may wish to know details of the events that led to death. It is in this step that nurses’ existing relationships with relatives will be useful – they may have an understanding of the relatives’ wishes regarding receiving information if they have communicated with them before.

The study by Jurkovich et al (2000) found a mixed reaction to the amount of detail families wanted. Only 13% of those studied wanted just general information with 30% requesting far more detail.

**Step 4**

Information should be given to relatives in an unhurried manner, giving them time to process the news and ask any questions (Cooke, 2000).

Technical language and jargon should be avoided to ensure the message is clear (Harrahill, 2005). Giving information in small chunks allows relatives to process it and reduces the likelihood of them becoming overwhelmed and not retaining any of the information (Buckman, 1992).

Nurses will often have an important role in deciphering information for relatives, reiterating it and explaining any terms they may not understand.
Discussion

Best practice guidelines

The guidelines developed by Buckman (1992) provide direction on breaking bad news. However, Farrell (1999) argued that some families felt healthcare professionals relied too much on formulas or guidelines, resulting in the loss of a personal element with no emotion shown.

Finlay and Dallimore (1991) used a retrospective questionnaire to investigate how parents felt the death of their child was handled. Results showed that participants were more satisfied with how the news of death was communicated to them by a police officer than by a nurse or doctor. These families felt they received a greater sense of empathy from police officers, who restrained their emotions less and appeared to be visibly upset when breaking the bad news. This gave the relatives the impression that the police officers had connected to them on a personal level (Finlay and Dallimore, 1991).

Buckman's protocol is widely followed with medical professionals. However, the suggestion that the news should not be imparted to relatives until step 4 conflicts with the opinion of another researcher. Harrahill (1997) said the death of the relatives was emphasized by Harrahill et al (2000) found that only 24% of relatives felt good attention had been paid in providing direction after death, showing this is an area requiring improvement.

After the relatives have been informed of the death, healthcare professionals should invite them to spend time with the deceased. According to Wright (1996), relatives feel they no longer have total ownership of their loved one next, such as carrying out last offices. They can also advise the family on when the death certificate can be collected, explain the format of the certificate, offer guidance on where to register the death and when they can begin to plan the funeral (Harrahill, 2005). The study by Jurkovich et al (2000) found that only 24% of relatives felt good attention had been paid in providing direction after death, showing this is an area requiring improvement.

Telephone communication

The literature is inconclusive on the preferred method of breaking news because relatives may have no support to hand immediately after receiving the news (Kendrick, 1997). Wright (1996) suggested if the hospital is near to the relatives, it would be best to tell them face to face. However, this leaves the nurse with the ethical dilemma of having to lie to relatives or avoid the truth. Kendrick (1997) suggested lying in this situation can be ethically justified as staff are trying to prevent harm to the relative, and are trying to provide the best possible environment for the news to be given.

However, staff may feel uneasy about lying, and may feel unable to do it due to their own morals. Wright (1996) said that, if the relatives live some distance from the hospital, it is essential to be honest and disclose the news of death. This is to prevent them rushing to the hospital, possibly endangering themselves.

Buckman (1992) said it is essential that healthcare professionals do not imply or state that a patient is alive if they are not. If asked a direct question about whether a patient is alive or dead, nurses must answer honestly, regardless of where they are in the process of breaking the news (Buckman, 1992).

If news must be broken over the phone, the informs should identify themselves at the beginning of the conversation and be certain of the identity of the relative, ensuring it is an adult (Harrahill, 1997).

When calling a mobile phone, it is vital to establish the location of the relative to ensure they are not driving or in an inappropriate place. If this is the case, they should be encouraged to move to a private, safe place where they can be called back (Taylor, 2007). This will act as a warning and help prepare the relative for the news to follow. The nature of a telephone conversation removes non-verbal support so it is crucial to listen intently and respond appropriately to relatives' reactions when breaking bad news over the phone (Taylor, 2007).

Although older literature mentions the need for support when attending the hospital (Adamowski et al, 1993; McLaughlan, 1990; Dubin and Sarnoff, 1985), it does not seem to have the same significance in recent literature. It is common sense to advise the next of kin to bring support, and...
it may not be included in protocols because it is done so routinely it is assumed health-care professionals will do this.

Healthcare professionals know it is better to break bad news in person. However, by avoiding the truth on the telephone, they may lose the trust of the patient’s family when they find out that the time of death was before they were contacted.

This has implications for nurses, particularly since the Nursing and Midwifery Council (2008) states that nurses “must be open and honest, and act with integrity”.

Non-verbal communication
The importance of body language should be considered throughout the conversation. Harrahill (2005) suggested that medical professionals should be seated, if possible, while breaking the news of death to reduce any “medical team intimidation” that the family may feel.

Regardless of the setting, medical practitioners should try and face the people they are communicating with, with uncrossed arms and good eye contact. Undoing jackets or laboratory coats can also help create a sense of openness (Harrahill, 2005).

The study by Jurkovich et al (2000) found that touch – through hand holding, hugging or a gently placed hand – was unwanted in 30% of participants, but 17% desired this human touch. The researchers noted that this may be gender dependent as those that objected to touch the most were men. Jones and Buttery (1981) found that relatives of patients who had died suddenly felt that being touched supportively and compassionately was beneficial to them. The researchers felt that being touched supportively and compassionately was beneficial to them.

However, these guidelines are not always followed. Jurkovich et al (2000) found that 19% of study participants described the attention given to the location of their conversation as poor. The study also found that 56% of participants felt the location of the conversation was of medium or high importance.

Farrell (1999) said public disclosure of bad news shows a lack of respect and consideration. This can have wider implications for families, such as a lack of confidence in other aspects of care.

Conclusion
Excellent communication skills when breaking news of death are essential. The importance of both verbal and non-verbal communication should be recognised, along with the significance of setting and attitudes of staff.

It is recognised how important good communication is when breaking news of death, but quality research on this subject is lacking. The guidelines and ideas around best practice are dated and do not appear to be evidence based. More research is needed to ensure conveying news of death is carried out appropriately.

References


