ORIGINAL PAPER

The Role of Health Care Professionals in Breaking Bad News about Death: the Perspectives of Doctors, Nurses and Social Workers

Michal Rassin, RN, PhD
Head, Nursing Research Unit, Assaf Harofeh Medical Center, Zrifine, Israel

Keren Paz Dado, RN, BA
Emergency Medicine Department, Assaf Harofeh Medical Center, Zrifine, Israel

Miri Avraham, RN, MA
Emergency Medicine Department, Assaf Harofeh Medical Center, Zrifine, Israel

Correspondence: Dr. Michal Rassin, Coordinator of Nursing Research, Assaf Harofeh Medical Center, Zrifine, Israel, 70300. E-mail address: rasinm@asaf.health.gov.il

Abstract

Background: The way a death is notified to family members has a long-term effect on their coping with their loss. The words caregivers use and the sentiments they express can stay with their hearers for the rest of their life.
Aims: To study the views of three caregivers groups—doctors, nurses and social workers—as to their role in breaking a death news in an ED.
Methods: One hundred and fifteen health care professionals participated in the research (51 nurses, 38 doctors and 26 social workers). They completed a 72-item questionnaire comprising behaviour descriptions, attitudes and statements. Content validation of the questionnaire was conducted by the help of experts group, and the internal reliability, measures in all its parts was 0.78 on average ($\alpha = 0.78$).
Results: Doctors gave a higher score than the other groups to their responsibility for breaking bad news ($p<0.005$) and to the content of the information they provide. Social workers scored the mental support given the family significantly higher than doctors and nurses did ($p<0.000$). Nurses scored the instrumental support given (tissues, water to drink) significantly higher than doctors and social workers ($p<0.000$). Breaking bad news caused social workers more mental distress than it did either doctors or nurses. All three groups gave a high score to the emotional exhaustion, sadness and identification this task caused them. Nurses felt more fear at the prospect of a notifying a death and made more effort to escape the task.
Conclusions: The findings of the study will help develop performance guidelines for notifying a death and provide input for simulation and other training workshops.

Key Words: Communication, Death Announcement, Health Care Professionals

Background

The hardest and most sensitive tasks in the whole of healthcare is to break bad news to a patient's family, whether it be that the patient is gravely ill or has died (Levetown, 2004; Parang, 2008). Israeli data show that, in 2009, Emergency Departments (ED) had to notify families of 1,361 deaths per year on average. As a result the task is of large dimensions (Park et al., 2010; Khaklai et al., 2011).

Studies among families of various patient groups have found that the elements they rank the most important are the health care professionals empathy, their honesty and clarity, giving the family time to ask questions and making reference to future issues (Muller, 2002; Lamont, 2003; Fallowfield & Jenkins, 2004). Girgis et al (1999) study of both doctors and family members reported that it was vital for caregivers to maintain eye contact and body language conveying a supportive message. Another study of 115 doctors and nurses found that the doctors were more satisfied with how they carried out their painful task than nurses were with the doctors' performance (Placek & Ellison, 2000). Doctors admit to having trouble containing the emotional reactions of patient and/or family. They report feeling of helplessness. Some even face accusations and blame-casting; others fear that they have not answered the family's questions adequately. Some even report a personal fear of sickness and death (Girgis et al., 1999).

Although the task of breaking bad news belongs by traditional to doctors, as it usually involves medical diagnosis, it transpires that other healthcare workers have a greater or lesser part to play at different times and circumstances. However, all health care professionals report that they are inadequately prepared and trained for the task (Price et al, 2006; Warnock et al. 2010). Although guidelines have recently begun to be drawn up and issued and workshops and simulations arranged, there is no research evidence as to their content, who attends them and what forms of support and communication they teach.

The research aimed was to study the views of three health care professionals groups—doctors, nurses and social workers—as to their role in breaking a death in an ED. The research questions were:

1. How does the respondent assess the way the news is broken in their ED (authority and responsibility, who does it and where)?
2. What information is given and how does the respondent rate its content, credibility and clarity?
3. What forms of non-verbal communication are employed?
4. What forms of verbal communication are employed?

Methods

Sample: A convenience sample was drawn from the research population of doctors and nurses working in the ED, doctors on duty in Internal medicine and Surgery wards, and hospital social workers. The final 115- sample comprised 51 nurses, 38 doctors and 26 social workers in one major hospital in the center of Israel's.

Instrument: From the literature and their own clinical experience the authors assembled 33 types of behavior and two or three statements to describe each one. The preliminary draft questionnaire contained 107 items, deliberately more than required so as to allow room for the elimination of unnecessary items in the process of content validation and pilot testing.

Content validation: Was examined by a panel of five experts, four of them ED staff: a nurse manager, a team head nurse, a social worker, a departmental head (doctor) and a researcher with experience in investigating the role of healthcare workers in breaking bad news). The panel went through every statement on the questionnaire examining it for clarity, pertinence and appropriateness to one of the content areas defined by the four research questions. This process eliminated 17 statements leaving an instrument of 90 statements for pilot testing. The instrument was tested on thirty respondents who were asked to record comments on the items' clarity, precision, muddle, etc. as a result of which a further eight statements were removed, leaving a total of 82.

Structural validation: This was accomplished by carrying out a factor analysis of the questionnaire. Items which appeared in two factors or which had factor loadings of less than 0.5 were removed from the instrument. This left 72 items with factor loadings of 0.5 and above. Respondent replies on the extent of their agreement with all items ranged on a 5-point

Likert scale from 1 – Not at all, to 5 – Very much so).

The Questionnaire: Part 1 gathered demographic and occupational data—gender, age, marital status, occupation, seniority, training and experience in breaking bad news. Next the respondent was asked about the way deaths were notified in their EMD (authority and responsibility, who did it and where).

Part 2 covered the information and support given to family members. Factor analysis of the 10 items relating to the type of information given had yielded three factors: *(a) Credibility* (4 items: the information given is credible; the true cause of death is given; the family has the right even to a painful truth; information liable to hurt the family is concealed);

(b) Information Content (3 items: the patient's state of health on admission; the treatment administered; cause of death); *(c) Clarity of the information given* (3 items: Notifier talks in straightforward language; Avoids using medical terminology; Explains and interprets the information given). An index was constructed for each of these three factors. The Cronbach alpha score for this part of the questionnaire was 0.75.

Factor analysis of the items designed to relate to the support given yielded high loadings for three factors: *(a) Mental Support* (5 items: Notifier stays with the family as long as needed; Lets the family vent emotions; Supports by empathic silence; Serves as resource support; Giving psychological aid is part of the role); *(b) Preparation and Process* (5 items: The notifier asks the family to sit before breaking the bad news; Ensures at least two family members are present (if available); Understands the task as a process, not a one-off action; Plans what to say in advance; Sets aside time to sit with the family; *(c) Instrumental support* (4 items: Offers water to drink, tissues. Two items loaded separately were: Supportive Contact (touching) and Offers Sedatives). The Cronbach alpha score for this part of the questionnaire was 0.8.

Part 3 (19 items) covered patterns of verbal communication by assessing the frequency of use of certain statements/comments. These grouped into six factors. With the first factor went two sentences which offered assistance (for example: "If you need any help, I am at your service"; "We shall try to help you in any way we can"). With the second factor went clarificatory comments (for example: "Do you want to come in and see your relative?" "What do you know about what has been happening?"). With the third factor went five offers of supportive information (for example: "He was admitted in a very serious condition"; "She was treated by an expert and skilled team"). With the fourth factor went five sentences offering sharing and emotional support (for example: "We share in your grief"; "You must try to stay strong"). With the fifth factor went remarks which the validating judges had labelled useless and empty (for example: "You must just accept the fact"; "It comes to all of us in the end") One item, labelled by the judges as an opening remark, was loaded separately ("I 'm afraid I have bad news to give you"). The Cronbach alpha score for this part of the questionnaire was 0.75.

Sample and Data Collection

After the research design had received approval from the Helsinki Committee of the hospital a self-administered questionnaires was distributed among the research population of doctors and nurses working in the EMD, doctors on duty in Internal Medicine and Surgery wards and hospital social workers. 150 questionnaires were distributed, 122 returned, of which seven were disqualified for incompleteness. The questionnaires were completed anonymously.

Data analysis

At the univariate level, the frequency distributions of all demographic variables and the means of all questionnaire items were calculated and cross-tabulated. At the multivariate level, a one-way ANOVA and post-hoc Scheffe test for differences between sample groups were employed. In addition, Spearman correlation coefficients were calculated for associations between variables.

Results

Demographic and Occupational Data

As Table 1 shows, of the nurses, doctors and social workers in the sample, the latter were somewhat the oldest and had the longest professional experience. Many more doctors had significant experience in breaking bad news than the other two groups but the doctors were the group the least trained for this specific task.

The way death is breaking in the ED

Participants: All three respondent groups were in equally full agreement that the authority and

responsibility in the ED for notifying the family of a death belonged to the attending doctor. All groups were agreed that it was vital a nurse be also present (M=4.32, SD=0.75), in particular the doctors (F=9.58, p=0.000). Agreement was also high that a social worker be present (M=3.38, SD=0.90), especially among the social workers themselves (F=5.64, p=0.02). When the respondents were asked to state from their own experience who actually participated the results were as follows: a doctor alone on 46.6% of the occasions; doctor and nurse 34.5%, doctor and social worker 13.6%, doctor, nurse and social worker 6.4%.

Location: In the great majority of cases the news was given in the doctor's own room in the EMD; in 11% of cases in the corridor and in the remainder of cases (8.3%) in a room where other uninvolved people were present (i.e. without privacy).

Table 1: Respondents' personal and occupational data by staff category (in percentages)

Variable	Categories	Nurses N = 51	Doctors N = 38	Social Workers N = 26
Gender	**Male**	**38**	**60**	**2**
	Female	**62**	**40**	**98**
Age (in years)	**Mean (SD)**	**36.5 (±8.6)**	**38.2 (±8.1)**	**42.7 (±11.76)**
Marital status	**Married**	**73**	**77**	**78**
	Single	**7**	**15**	**10**
	Divorced	**17**	**5**	**10**
	Widowed	**2**	**2**	**2**
Seniority	**Mean (SD)**	**10.9 (±8.7)**	**10.5(±8.2)**	**15.3 (±8.3)**
No. of times they had notified a death	**More than 10**	**27**	**63**	**28**
Had received training in breaking bad news	**——**	**51**	**39**	**64**

Table 2: Features of the Information Given

(Respondent replies ranged from 1 – Not at all, to 5 – Very much so)

Indices and items	Doctors		Nurses		Social workers		F ratio	P value
	M	SD	M	SD	M	SD		
Information Credibility index	**4.14**	**0.66**	**3.71**	**0.94**	**4.08**	**1.03**	**3.07**	**4.05**
Information given is credible	4.15	0.82	3.96	1.04	4.38	0.94	1.73	NS
Information liable to hurt family is concealed	3.71	1.01	4.22	0.96	4.60	0.64	8.39	0.000
True cause of death given	4.16	0.89	3.64	1.12	3.90	1.41	2.24	NS
Family has right to even painful truth	4.10	0.78	3.38	1.17	3.92	1.23	3.72	0.02
Information Content index	**4.25**	**0.62**	**4.07**	**0.93**	**3.66**	**1.05**	**5.22**	**0.007**
Patient's state of health on admission	3.98	1.20	3.42	1.22	2.95	1.3	5.37	0.006
Treatment administered	3.53	1.40	3.30	1.23	2.57	1.82	5.33	0.005
Cause of death	4.31	0.57	4.32	1.03	3.7	0.80	7.29	0.001
Information Clarity index	**3.99**	**0.62**	**3.61**	**0.73**	**4.14**	**0.52**	**6.81**	**0.02**
Medical terminology avoided	4.05	0.97	4.10	0.78	4.46	0.64	2.16	NS
Straightforward language	4.65	1.21	4.72	1.11	4.96	0.85	1.73	NS
Information explained and interpreted	4.31	0.57	3.50	1.21	3.00	1.02	18.78	0.000

NS = Not significant

Table 3: Patterns of Support
(Respondent replies ranged from 1 – Not at all, to 5 – Very much so)

Indices and items	Whole Sample		Doctors		Nurses		Social workers		F ratio	P value
	M	SD	M	SD	M	SD	M	SD		
Mental Support index	**3.73**	**0.67**	**3.54**	**0.66**	**3.49**	**0.49**	**4.47**	**0.40**	**31.40**	**0.000**
Lets family vent emotions	4.17	0.82	3.92	0.91	4.02	0.74	4.84	0.74	13.94	0.000
Serves as resource support	3.99	0.92	3.68	1.06	3.84	0.79	4.73	0.45	13.47	0.000
Psychological aid is part of the job	3.65	1.29	3.21	1.23	3.60	1.26	4.38	0.22	7.04	0.001
Stays with family as long as needed	3.41	1.13	3.28	1.18	2.92	0.91	4.57	0.50	26.98	0.000
Supports by empathic silence	3.36	0.99	3.28	1.01	3.22	0.94	3.37	1.00	2.43	0.09
Preparation and Process index	**3.75**	**0.76**	**3.72**	**0.85**	**3.62**	**0.59**	**4.05**	**0.87**	**2.85**	**0.062**
Asks family to sit before notifying	3.89	1.08	3.92	1.19	3.81	0.90	4.00	1.25	0.25	NS
At least 2 family members present (if available)	3.85	1.04	3.65	1.23	3.76	0.92	4.32	0.80	3.51	0.03
Process, not a one-off act	3.82	1.08	3.84	1.00	3.74	1.11	3.96	1.18	0.34	NS
Plans what to say in advance	3.79	1.08	3.65	1.16	3.8	0.98	4.00	1.13	0.76	NS
Makes time to sit with family	3.32	1.17	3.23	1.05	2.82	1.01	4.42	0.90	22.11	0.000
Instrumental Support index	**3.70**	**1.07**	**2.94**	**1.13**	**4.11**	**0.62**	**4.01**	**1.12**	**18.30**	**0.000**
Offers water to drink	3.93	1.17	3.39	1.32	4.38	0.67	3.88	1.36	8.80	0.000
Offers tissues	3.45	1.31	2.5	1.26	4.11	1.31	3.84	0.99	21.04	0.000
Supportive contact	3.45	1.13	3.28	1.08	3.29	1.22	4.00	0.84	4.13	0.01
Offers sedatives	2.41	1.27	2.7	1.35	2.44	1.28	1.87	0.99	3.30	0.04

Table 4: Patterns of Verbal Communication
(Respondent replies range from 1 – Not at all, to 5 – Very much so)

Indices and items	Whole Sample		Doctors		Nurses		Social workers		F ratio	P value
	M	SD	M	SD	M	SD	M	SD		
Help index	**3.98**	**1.00**	**3.61**	**1.08**	**3.96**	**0.99**	**4.58**	**0.56**	**7.50**	**0.001**
If you need any help, I am at your service	4.05	1.04	3.58	1.10	4.04	1.00	4.79	0.50	11.41	0.000
We shall try to help you in any way we can	3.89	1.10	3.63	1.19	3.85	1.11	4.37	0.76	3.40	0.03
Clarification index	**3.72**	**0.94**	**3.50**	**0.79**	**3.71**	**0.96**	**4.08**	**1.04**	**2.82**	**0.06**
Do you want to come in and see your relative?	4.32	0.91	4.19	0.855	4.38	0.90	4.41	1.05	0.56	N.S
What do you know about what has been happening?	3.09	1.30	2.80	1.30	3.02	1.24	3.70	1.29	3.54	0.32
Supportive Information index	**3.41**	**1.43**	**3.89**	**2.01**	**3.20**	**0.88**	**3.11**	**1.04**	**3.35**	**0.03**
She was treated by an expert and skilled team	4.17	5.04	4.97	8.53	3.66	1.15	4.00	1.11	0.73	N.S
We did all we could	3.60	1.29	4.21	0.96	3.53	1.13	2.73	1.57	11.11	0.000
He was admitted in a very serious condition.	3.38	1.15	3.83	1.01	3.24	1.21	2.90	1.02	5.33	0.006
She did not suffer	3.06	1.24	3.43	1.04	2.75	1.28	3.13	1.32	3.31	0.04
He was already lifeless by the time he arrived here	2.75	1.31	3.02	1.38	2.62	1.29	2.52	1.17	1.32	NS
Sharing and Support index	**3.24**	**0.74**	**3.09**	**0.63**	**3.40**	**0.77**	**3.15**	**0.80**	**2.19**	**NS**
We share in your grief.	4.34	0.88	4.37	0.75	4.44	0.73	4.08	1.28	1.35	NS
You must try to stay strong	3.32	1.31	3.67	1.13	3.67	1.17	2.08	1.10	18.06	0.000
I understand how you feel	3.05	1.31	2.80	1.26	3.22	1.31	3.08	1.37	1.07	NS
If only I had better news	2.72	1.35	2.33	1.24	2.89	1.26	2.95	1.60	2.32	NS
I admire your courage	2.63	1.22	2.05	1.01	2.65	1.25	3.52	0.94	12.12	0.000
Opening Statement: I am sorry I bring bad news	2.97	1.34	3.56	1.21	2.72	1.28	2.54	1.41	6.16	0.003
Useless remarks index	**1.67**	**0.72**	**1.65**	**0.74**	**1.67**	**0.76**	**1.68**	**0.61**	**0.97**	**NS**
A hard time is ahead	1.98	1.03	1.78	0.94	1.79	0.87	2.69	1.18	7.90	0.001
You have to accept it	1.71	0.91	1.80	1.03	1.85	0.93	1.26	0.44	3.76	0.02
Things will get better	1.68	1.02	1.83	1.18	1.66	0.90	1.50	1.02	0.76	NS
It comes to us all	1.26	0.73	1.22	0.77	1.26	0.70	1.33	0.76	0.14	NS

What information is given and how does the respondent rate its content, credibility and clarity: All three indices scored high among all three respondent groups: Credibility 3.94 ± 0.9; Clarity 3.85 ± 0.68; and Content 3.95 ± 0.9. Table II shows that with respect to most of the Credibility items the nurses gave the lowest mean score, that the social workers gave the lowest mean score on Content items and that the doctors scored the Information Explained and Interpreted item of the Clarity index exceptionally high.

Patterns of Support

What forms of non-verbal communication are employed: Table 3 shows that with respect to the whole sample all three indices scored from moderate to high (3.73, 3,75, 3.70 respectively) but that social workers scored the mental support given significantly higher than the other two groups. With respect to Preparation and Process, the inter-group differences were small although again the social workers gave this the highest score. On Instrumental Support, the nurses gave the highest score, the social workers almost as high but the doctors significantly lower than the other two groups.

Supporting by physical contact (holding a hand, stroking, hugging) was scored particularly highly by the social workers. Of all four items in the Instrumental Support index, offering sedatives received much the lowest score, in particular by the social workers.

What forms of verbal communication are employed: As Table 4 shows, when the index scores are ranked from high to low then the Help and Clarification indices are scored significantly highest by the social workers while the Supportive Information index scores highest among doctors and nurses. Scores for the Sharing & Support index do not differ significantly between the respondent groups. The opening remark "I'm afraid I have bad news for you" was scored highest by doctors. The index of 'Useless Remarks' was scored far lower than all other indices by all groups equally.

The most frequently employed statements/comments, ranked from high to low, were: "We share your grief"; "Do you want to come in and see your relative?" and "She was treated by an expert and skilled team". The least frequently employed comments, unsurprisingly, were: "Things will get better" and "It comes to all of us in the end."

Discussion

This study examined the role of the health care professionals in breaking bad news about death from three points of view: the doctors, nurses and social workers which participant in the situation.

The first issue broached was who, in addition to a doctors should be present at the breaking of bad news. There was general consensus that a nurse should participate. Her role is vital: she provides support to the family and 'translates' the bad news to them. She helps them 'take in' the announcement and provides some continuity after the doctor has returned to his/her other patients (Price et al., 2005). However, the social worker's attendance is also important. She has additional long-term support to offer and her availability releases the nurse to return to her ongoing duties (Levetown, 2004).

As for where the news is broken, this study has shown that in a non-negligible number of cases the place chosen gave the family no privacy. The study by Jurkovich, Pierce, Pananen and Rivara (2000) found exactly the same: the families are told the news in the corridor, a waiting room and other places where everyone's eyes are on them.

With respect to the nature and content of the information given the family, the present study reveals significant differences between the three respondent groups. All three scored the information's credibility high but the nurses' ranking was significantly less high than the other two groups'. Perhaps the nurses wanted to protect the family by sparing them painful knowledge. In the only other research study into this topic, 54 family members of persons who died in an ED reported that for them the key elements of the announcement were its privacy, the clarity and credibility of the information given, and the genuine sympathy shown by the person making the announcement. When asked about the amount of information they wanted to hear as to the cause of death, a third said they preferred a detailed explanation but 13% preferred an explanation in more general terms which would spare them difficult aspects. A quarter asked that the announcement of a death open with an explanation in general terms and only proceed to further detail if the family requested it (Jurkovich et al., 2000). In some instances, the healthcare workers breaking the news have a divergent understanding of their role and responsibility and differing views as to how much information should be revealed. When this happens or when the language used includes professional

terminology which the family cannot understand, the outcome is that family members feel confused and angry (Schubert & Chambers, 2005; Kamar et al., 2009).

A third issue the present study probed into was how the notifying team behaved. The social worker respondents ranked mental support significantly higher than doctors and nurses did and not surprisingly so for their training focuses on giving exactly this in times of need. By contrast, the doctors and nurses reported a tendency to 'seek relief' by offering instrumental support, such as sedatives, tissues and a drink of water. Less frequent forms of support-giving were physical contact and making space for the family to vent their emotional reactions. Facing and coping with outpoured emotion—shock, anger, grief, sobs and shouting—is indeed one of the hardest aspects for healthcare workers of breaking bad news (Fallowfield & Jenkins, 2004). Some workers respond by maintaining professional detachment and others by the attitude that giving psychological assistance is not their job (Barnett, 2004; Price, et al; 2006). Jurkovich et al. study (2000) found that a third of family members who had gone through the experience of such an announcement in an ED did not appreciate having staffers grip their hands, pat them on the shoulder or hug them. Others were more appreciative. This response depends greatly on the culture the family members come from and staff must take this into account.

Notice of a close relative's unexpected death is the hardest news someone can receive. The shock for those who knew and loved the deceased is enormous but with it come feelings of fear, helplessness, self-blame, "This can't be happening", and frequently "Why wasn't it me?" Even when the bad news has been anticipated it is more painful than one expects. Research has shown that in both cases, an unexpected or anticipated death, family members will ask staff whether everything was done to save the relatives' life and/or ease their end, whether they died peacefully or in pain (Levetown, 2004). This is why statements such as "She was treated by an expert and skilled team", "We did everything we could to save him" and/or "to ease his end" or "She did not suffer" bring some relief to family members and help them cope with their loss and pain. This study confirms what others have reported, namely, that statements which seek to comfort by diverting grief to 'positive' aspects, such as "It's better for him this way", are best avoided and replaced by saying candidly what one feels, such as "I am truly sorry" (Barnett, 2004; Levetown, 2004).

The study limitations: The sample from each respondent group is relatively small and drawn from one medical center only. Family members who had received notice of a death in an ED were not included because of the sensitivity of the topic and the ethical difficulty of approaching them soon after a deep crisis and trauma.

Despite its limitations, this research has several advantages: the comparison conducted between three main groups of caregivers. This multi-dimensional approach should help develop policy guidance and provide content for simulation workshops. Although the professional literature contains a wealth of recommended approaches to the task of breaking bad news few of these are research-based. Therefore, the current research aims at adding another layer to the growing body of knowledge in the field.

The recommendations this research proposes are a base for consideration or discussion for the hospital’s policy changes in this particular issue:

- A nurse and social worker should accompany the doctor when he/she notifies family members of a death. The doctor will be the first to leave to return to his other patients, then the nurse, leaving the social worker to stay with the family as long as they need her.
- The announcement must be made in conditions of undisturbed privacy. The family members should be invited to sit down and the staff should maintain eye-contact with them.
- The first announcement of the bad news should leave the family time to 'absorb' the shock. They should be told that once they are ready the explanations can continue. Health care professionals should try to sense the pace of proceedings best suiting each family and how much they wish to be told. They should be asked if they have understood what they have heard and, if not, information should be repeated and clarified. When the family stop asking questions this is a sign that they have heard all they want to hear: further details will only cause suffering. If they want later to put further questions this should be allowed for.

- Health care professionals should prepare for a wide range of reactions, among them shock, sobs, anger, shouts of denial, and bargaining. They have to allow space and time for these, show by their own behavior that these are legitimate reactions and demonstrate empathy and concern.
- Health care professionals should remain calm and avoid any defensive response, even in the face of accusations against them. Whatever the family members' reaction, staff must respect it and remain supportive in all circumstances.
- Health care professionals should stay with the family and show support by empathic silence and soothing physical contact. Placing one's hand on a shoulder or gripping a hand communicates warmth, condolence and concern. Likewise, offering water to drink, tissues and sedatives. However, useful as physical contact can be, staff should watch for unspoken signs that the family prefers to maintain distance and respect this.
- Sad or tearful looks from the caregivers are not interpreted by family members as signs of weakness or lack of professionalism, rather as showing that their family member was treated in their last moments by a warm-hearted and concerned person.
- Verbal communication will concentrate on showing empathy, compassion and sharing but will include items of information and offers of support. It is critical to assess how much the family already knows and to affirm that the treatment staff did all they could to save the patient's life and/or ease their suffering. Attempts to give relief by pointing out 'positive' aspects should be avoided.
- Breaking bad news must be accepted from the outset as a process to be gone through, not a one-off action. The family need time to take in the news, so staff must show patience, understanding and containing.
- Since breaking bad news is a task which requires skill and planning, health care professionals need to be trained in advance. Discussing how to do it with experienced colleagues, simulations and workshops are all helpful forms of training.

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