

## Delivering Bad News

### A Pilot Program

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## **DELIVERING BAD NEWS**

### **INTRODUCTION:**

This series of five sessions addressing “Delivering Bad News” has evolved based upon the realization that during our formal medical training, no time has been allotted in the curriculum to explore and examine the impact of “delivering bad news”. Further experience and participation in parental bereavement and support groups has demonstrated that the manner in which “bad news” sessions are conducted can have an important and long lasting effect on the families involved. Although it is clearly understood that each family is unique and each health care provider’s background is unique, there are certain commonalities that seem to emerge which can facilitate “bad news” sessions going smoothly. There is clearly no “right way” or “good way” of delivering bad news. However, by focusing a few minutes each week on this area, one can begin to identify and explore issues related to “bad news” sessions.

The format of case scenarios with videotaped-filmed sessions has been adapted to allow participants to evaluate and critique themselves during mock “bad news” sessions. We believe that the primary motivator to behavior change is critical self-critique. The major objectives of this program are:

1. to identify those experiences that each of us brings to the “bad news” session
2. to identify, understand and organize the roles of each of the participants of the “bad news” sessions
3. to become aware of the common responses that help or hinder families from responding to “bad news”
4. to sharpen the skills of self-evaluation in determining how a “bad news” session went
5. to become increasingly aware of what each of us takes away from a “bad news” session and how it may affect us.

The attached material has been designed so that facilities may be guided through five sessions focused on these issues. The guidelines provided simply provide a template off of which individually based case scenarios may be designed.

**DELIVERING BAD NEWS**  
**OUTLINE FOR THE SESSIONS**

**Week 1**

- Objective/Outline of 5 Sessions
- Pre-evaluation
- Solicit background “Bad News” Information from Participants
- A. Checklist
  1. Entering the Room
  2. Body of Session
  3. Do’s and Don’ts Handouts
  4. Exiting Room
- Do’s and Don’ts handouts

**Week 2**

- Review if bad “Bad News” – 5 min: Case Scenario
- Participants Evaluate Video – Then Re-enact Mock Code Case Scenario

**Week 3**

- 3 Mock Code Case Scenarios: Video Participants
- Verbal Self-evaluation of Participants

**Week 4**

- Parental Feedback – Discussion Held by Parent of Child who has Died or Received “Bad News” (i.e.: SIDS, Cardiac, Trauma, Oncology)
- Hand Out Background Material on Death/Dying

**Week 5**

- Review of Videos and Self-Critique
- Discussion of 10 commonly asked questions
- Post-evaluations

**6 month Review**

- Send out 6 month evaluations

**“BAD NEWS” CHECKLIST:**

**STARTING/ENTERING THE ROOM**

Introductions/identifying family and support personnel  
Physical layout/seating arrangement  
Appropriate effect on entering room  
Use of patient’s name  
Empathy – did you start with I’m sorry?

**BODY OF SESSION: DO’S AND DON’TS**

Appropriate effect/body language  
Single statements/no medical jargon  
Used patient’s name  
Allowed time to think/process/question/grieve  
Expressed sadness/empathy  
Addressed parents equally  
Provided reassurance that patient did not suffer  
Told the “truth”

Did not patronize or protect  
Did not look at watch or yawn  
Did not say, “I know how you feel”

**EXITING ROOM:**

Chose appropriate time to exit  
Solicited questions before leaving  
Prepared parents for what they will see/be asked  
Ensured support person available  
Re-stated regrets on outcome

**HOW TO START**

- A. Be sure you:
- Have a private room / space with enough chairs and tissues.
  - Have necessary paperwork filled out and know what needs to be completed.
- B. Ask family who they would like to be with them.
- C. Ask family if they would like a chaplain called.
- D. Use other professional to convey information and update until you're available.
- E. Recognize cultural differences, be aware of language barriers.
- F. Take into account psychosocial characteristics.

**ENTERING THE ROOM**

- A. Identify a support person who will prepare family for your arrival and will help you over the rough spots.
- B. Calm down; prepare yourself emotionally for what you are about to do. Your affect must equal the message.
- C. Introduce yourself and role in the unit.
- D. "I'm sorry, I have very bad news for you".
- E. Patient (use name) died because ... give chronology of events.
- F. Take cues from family. Stay with their emotion and needs.

**HOW TO GET OUT OF THE ROOM**

- A. Be aware of change in level and pacing of conversation (more silence, less intensity).
- B. Family members may ask "What do we do now?"
- Answer: (I need to get you some papers to sign or you can visit patient if you'd like, etc.)
- C. Ask:
1. What can we do to help you get through this?
  2. Do you have any questions I can answer before I go?
  3. Would you like to see the patient? Let me check.
  4. Do you need time alone?
  5. Is there anyone I can call for you?
  6. Go get paperwork.
  7. Do you need to talk with someone about funeral arrangements or explaining things to other children?
- D. Before leaving, again state how sorry you are and you wish it would have been different, and say you can be available at future time – give them a card with your name and phone number.

**DO'S**

- Be aware of effect, body language, seating arrangements
- Say things simply – stay away from jargon
- Repeat information in different way
- Give time to think, process information and ask questions
- Let family set the pace, not all people go through a crisis at the same rate
- Emphasize that everything possible was done
- Use family names – use child's name, refer to child by name
- Express your personal frustration and sadness about outcome (we tried so hard, this is so sad to me, he looked like such a happy child)
- Gear information and approach to s/e/s and education level
- Stay with the families' defenses
- Ask "Does your faith help you", or "How do you find strength during bad times?"
- Reassure them that they are not to blame, that they behaved well (that behaving otherwise would not have altered outcome)
- Treat parents equally (don't forget, fathers hurt too)
- If appropriate, be "Touchy"; it's the most basic form of comfort
- Help the family reminisce
- Encourage the family to talk about the event
- Be aware of the possible range in grief reaction (see handouts)
- Reassure family that the child did not suffer
- Ensure availability of support/follow-up in hours/day that follows initial session (i.e. don't tell someone they have CA on Friday PM if Oncologist is out of town Friday-Sunday – without F/U)

**DON'TS**

- DON'T expect them to be logical or objective
- DON'T be surprised by any reaction
- DON'T patronize or protect
- DON'T check your watch
- DON'T have judgments about "Things are better this way ... he would have been a vegetable; at least he's with God; at least he's not suffering". Parents want their children to survive.
- DON'T bring in paperwork
- DON'T say you know how they feel

**BAD NEWS CASE SCENARIOS**

**OBJECTIVES:**

Delivering death news, understanding of lay explanation of brain death/organ donation, acute crisis intervention.

CASE #1 Acute Traumatic Injury Leading to Brain Death: Motor Vehicle Accident

CASE #2 Gunshot Wound to Head: Brain Death

**OBJECTIVES:**

Supporting family while convincing of necessity of procedure, organizing and defusing “difficult” parents.

CASE #3 Parental Distrust – Arrest after transfer to floor

CASE #4 Informal Consent – LP consent from a distrustful parent

**OBJECTIVES:**

Notification of DCPS and police involvement with family, maintaining empathy/neutrality when abuse/neglect suspected.

CASE #5 Near Drowning

**BAD NEWS CASE SCENARIO****CASE EXAMPLE:** BAD "BAD NEWS" SCENARIO

A one-month old female, previously healthy baby living with her mother and the mother's boyfriend was put to bed after dinner the previous night. At 9:00 a.m., the mother went in to check on the baby and says she found her blue, apneic, and stiff. The mother screamed, started CPR, and had her boyfriend dial 911. The baby arrived in full arrest. After 25 minutes, the baby was successfully resuscitated and transferred to the PICU on inotropic support and mechanical ventilation. There are some resolving bruises over the baby's buttocks but no other signs of external trauma. The mother and her boyfriend are in the Parent Room and you are designated to inform them of the child's status, the fact that DCPS and the police will be involved.

**PARTICIPANTS:**

Mother, boyfriend, doctor

**PHYSICIAN'S TASKS:**

1. Inform parents of patient's status
2. Explain that DCPS/police will be involved
3. Question where buttocks bruises came from
4. Get a history of the event

**DURATION ALLOTTED FOR SCENARIO:**

Ten minutes maximum

**BACKGROUND INFORMATION FOR SUPPORT PERSON:**

This couple has been together for 6 months and the boyfriend is not the father of the baby.

**"BAD" SCENARIO SUGGESTIONS:**

1. Doctor to stand, introduce self as "the doctor" (without name).
2. Use words like "your child", "mom" and "dad" even though the boyfriend is not the dad.
3. Use jargon for describing patient status; "your child is really critically ill. CPR was successful but she's on inotropic support and a mechanical ventilator."
4. Mother and boyfriend should pretend not to understand the jargon and insist that the ET tube be removed.
5. Doctor placates family. Starting, "don't worry about that. I know how you feel, but we need to find out a few things. I know you said you put her to bed last night after dinner, didn't you check on her during the night? How did she get those bruises on her bottom? They look like abuse is a possibility and DCPS/the police will be contacting you soon."
6. Doctor gets beeped on pager. Starts to explain that "I have other patients who I need to take care of and I don't have any more time to talk about your child right now. I'll try to talk to you about this later."
7. Parent cuts in that "I need a cigarette. How can you talk about other children when my baby is so sick? I'm going to get a cigarette". Mother leaves the room and boyfriend remains seated. Doctor looks stunned, doesn't know whether to go after the mother or remain with the boyfriend. After a minute he says, "Don't worry about her, she'll be alright. She needs some time to herself. They always come back. This happens to me all the time."

**BAD NEWS CASE SCENARIO**

**CASE EXAMPLE:** REENACTMENT OF BAD “BAD NEWS” SCENARIO

NEAR SIDS: “DIFFICULT” FAMILIES

A one-month old female, previously healthy baby living with her mother and the mother's boyfriend was put to bed after dinner the previous night. At 9:00 a.m., the mother went in to check on the baby and says she found her blue, apneic, and stiff. The mother screamed, started CPR, and had her boyfriend dial 911. The baby arrived in full arrest. After 25 minutes, the baby was successfully resuscitated and transferred to the PICU on inotropic support and mechanical ventilation. There are some resolving bruises over the baby's buttocks but no other signs of external trauma. The mother and her boyfriend are in the Parent Room and you are designated to inform them of the child's status, the fact that DCPS and the police will be involved.

**PARTICIPANTS:**

Mother, boyfriend, doctor, support person, primary nurse

**PHYSICIAN'S TASKS:**

1. Inform parents of patient's status
2. Explain that DCPS/police will be involved
3. Question where buttocks bruises came from
4. Get a history of the event

**DURATION ALLOTTED FOR SCENARIO:**

Ten minutes maximum

**BACKGROUND INFORMATION FOR SUPPORT PERSON:**

This couple has been together for 6 months and the boyfriend is not the father of the baby.

**INSTRUCTIONS TO FACILITATOR:**

Have the group reenact the bad “bad news” scenario above and try to do it better than seen on tape.

**BAD NEWS CASE SCENARIO****CASE #1** ACUTE TRAUMATIC INJURY LEADING TO BRAIN DEATH: MOTOR VEHICLE ACCIDENT

A 5-year-old white male, previously healthy, was being cared for by a baby sitter while his parents were at work. His mother and father are separated, and he lives with his mother. According to the sitter, while playing kickball on the lawn, he ran out into the street between two parked cars and was struck by a car traveling at an excessive speed. The car did not stop.

He was apneic and comatose at the scene and arrived in the Emergency Department in full cardiopulmonary arrest with CPR in progress. His injuries included a skull fracture, C spine fracture, femur fracture, and abdominal trauma. After 30 minutes of unsuccessful resuscitation, he developed a spontaneous heart rate and blood pressure but no evidence of cerebral activity. Twelve hours later, his pupils are fixed and dilated and you return to inform the parents that his brain has herniated and he meets criteria for brain death.

**PARTICIPANTS:**

Mother, baby-sitter, father, doctor, support person, primary nurse

**PHYSICIAN'S TASKS:**

1. Inform parents of patient's status.
2. Briefly explain brain death.
3. Mention potential for organ donation.
4. Mention need for medical examiner autopsy.

**DURATION ALLOTTED FOR SCENARIO:**

Ten minutes

**BACKGROUND INFORMATION FOR SUPPORT PERSON:**

Mother and father have been separated for two years and are litigating for custody of the child. The father resents the fact that the baby-sitter and the mother always seem to agree with each other. The father feels that if he had been watching the child that this could have been avoided.

**SUGGESTED ISSUES DURING MOCK SCENARIO:**

1. You're so young, -- can I talk to a real doctor; are you a nurse?
2. What do you mean I can't smoke? This is the time I need a cigarette most.
3. Can I see him right now?
4. Is he feeling any pain?
5. Brain death: When I squeeze his hand, he seems to squeeze back.
6. Are you sure he can't recover -- he has no chance? I've read about people waking up from a coma.
7. Everyone keeps telling me to talk to him and touch him. If you're telling me he's brain dead, can he really hear me?
8. Organ donation: Will we still be able to have a viewing?
9. Organ donation: What if he was your child?
10. If he's brain dead, let's just stop everything. Why does he have to have an autopsy? We know what happened.
11. Can I hold my child even with all those tubes?
12. How long do we have to make this decision?

**BAD NEWS CASE SCENARIO****CASE #2** GUNSHOT WOUND TO HEAD: BRAIN DEATH

A 13-year-old adolescent male is admitted to the PICU sustaining a gunshot wound to the head. He was accidentally shot by his schoolmate while playing with a gun that they thought was not loaded.

In the Emergency Department he is resuscitated and has a heart rate and blood pressure but no evidence of cerebral activity. The neurosurgeon has told the parents that he is “brain dead” and has no chance for neurologic recovery. He is admitted to the PICU for hemodynamic support of other organs so that the parents can be approached for organ donation. While in the PICU, there is a question whether some motor activity is purely spinal reflex or whether the patient might be posturing to painful stimuli. For this reason, a formal brain death evaluation including EEG’s is felt to be necessary. You are sent into the room to discuss with the parents the need for a more prolonged workup for brain death, as well as to address the issues of organ procurement and medical examiner autopsy. Background information includes that the mother does not want organ donation or autopsy to be performed, but that the father strongly urges organ donation. The family is supportive to one another, but differs in their opinions as to what should be done.

**PARTICIPANTS:**

Mother, father, doctor, support person, brother, primary nurse

**PHYSICIAN’S TASKS:**

1. Inform parents of patient’s status.
2. Explain brain death.
3. Mention potential for organ donation.
4. Mention need for medical examiner autopsy.

**DURATION:**

Ten minutes

**BACKGROUND:**

This is the only child for this father, but the 5<sup>th</sup> child for mother – child has 4 adult siblings – ranging 18 – 25. Mom is totally against organ donation – father very supportive of organ donation. Brothers have difficulty with accepting this father’s “pushiness”.

**SUGGESTED ISSUES DURING MOCK SCENARIO:**

1. You’re so young, -- can I talk to a real doctor; are you a nurse?
2. What do you mean I can’t smoke? This is the time I need a cigarette most.
3. Can I see him right now?
4. Is he feeling any pain?
5. Brain death: When I squeeze his hand, he seems to squeeze back.
6. Are you sure he can’t recover – he has no chance? I’ve read about people waking up from a coma.
7. Everyone keeps telling me to talk to him and touch him. If you’re telling me he’s brain dead, can he really hear me?
8. Organ donation: Will we still be able to have a viewing?
9. Organ donation: What if he was your child?
10. If he’s brain dead, let’s just stop everything. Why does he have to have an autopsy? We know what happened.
11. Can I hold my child even with all those tubes?
12. How long do we have to make this decision?

**BAD NEWS CASE SCENARIO****CASE #3** PARENTAL DISTRUST: ARREST AFTER TRANSFER TO FLOOR

A five-month-old S/P 28-week-premature infant who is discharged from the Intensive Care Nursery three weeks ago presents to the Emergency Department after a cyanotic spell at home with apnea. By the time the EMT's arrive in the Emergency Department, the patient is awake, alert and playful, and the patient is admitted to the PICU for monitoring. After three hours of monitoring in the PICU without abnormality, the patient is transferred to a floor, monitored bed to make room for two incoming severely injured pediatric motor vehicle traumas. The parents are sent to the Admissions Office and stopped in the cafeteria afterwards.

Within 15 minutes of arrival on the floor, the 5-month-old has a respiratory arrest requiring CPR, mechanical ventilation and a central IV line for resuscitation. The patient is normotensive but is not responding to deep pain at this point. The pediatric traumas that have been admitted to the PICU have taken the last two beds and now there is currently no room to transfer the 5-month-old back to the PICU. The possibility of transfer to another hospital has been mentioned. Just then, the parents arrive on the floor after returning from the cafeteria and ask if it is okay to visit. You are sent to inform them of the patient's current status and inform them of the difficulty with the bed situation.

**PARTICIPANTS:**

Mother, father, doctor, support person, primary nurse

**PHYSICIAN'S TASKS:**

1. Inform parents of patient's status.
2. Inform them of the bed situation

**DURATION ALLOTTED FOR SCENARIO:**

Ten minutes

**BACKGROUND INFORMATION FOR SUPPORT PERSON:**

Married couple – angry that their child was discharged from PICU only after three well meaning hours to make room for incoming traumas. The parents were encouraged by meaningful staff member to “go have a bit to eat” and be sure to give insurance information to the Admission Office.

**SUGGESTED ISSUES DURING MOCK SCENARIO:**

1. I knew something like this was going to happen; I didn't think he was ready to come out of the ICU.
2. Why was it so important for us to go down to the Admission Office to give information? We would have been there.
3. Could this have been prevented if he hadn't been moved around?
4. How long will it be before he can come off the ventilator?
5. Does he have any damage due to his apnea (lack of O<sub>2</sub>)? Will he live?
6. Is putting in the central line painful?
7. When can I be with my child. I'm not ever leaving his side again.
8. No room in the ICU? We were here first and our baby could and almost did die.
9. Can you assure me nothing will happen to my baby during the move? I must be with him during the transport.
10. I want to see the top administrator. This is just unacceptable.

**BAD NEWS CASE SCENARIO****CASE #4** INFORMED CONSENT: LP CONSENT FROM A DISTRUSTFUL PARENT

A one-year-old male presents to an outside hospital's Emergency Department with a prolonged tonic-clonic seizure, fever, and respiratory arrest necessitating intubation and mechanical ventilation. After treatment with valium and phenobarbital intravenously, the patient is stabilized, a first dose of antibiotics is pushed, and the patient is transferred by helicopter to the PICU. On arrival, the patient is hemodynamically stable but unresponsive. No parent is available at this time. The patient is admitted to the PICU and prepared for lumbar puncture. The patient is prepped and draped and the resident is poised to begin the lumbar puncture. Just then, the mother opens the door and demands to see her child. You are designated to discuss the patient's current status and obtain consent for the lumbar puncture.

**PARTICIPANTS:**

Mother, doctor, support person, primary nurse

**PHYSICIAN'S TASKS:**

1. Discuss the patient's current status
2. Obtain consent for lumbar puncture

**DURATION ALLOTTED FOR SCENARIO:**

Ten minutes

**BACKGROUND INFORMATION FOR SUPPORT PERSON:**

Mother refuses lumbar puncture secondary to her prior experience of recurrent headaches, which she attributes to prior epidural anesthesia during childbirth. She insists on being present during the procedure if it's going to be done.

**SUGGESTED ISSUES DURING MOCK SCENARIO:**

1. Why didn't they tell me that at the other hospital?
2. Can we get better treatment at another hospital?
3. How many times have you done this before?
4. Will the spinal tap cause headaches for him like it did for me?
5. Can't my child become paralyzed from the spinal tap?
6. I'm going to stay in the room while you do this procedure. Were you actually going to do it without my consent?
7. Please, can I see my child right now?
8. Both his father and I need to be here overnight with him. We are both worried and neither of us want to leave the other.

**BAD NEWS CASE SCENARIO****CASE #5** NEAR DROWNING: “DIFFICULT” FAMILIES

A three-year-old drowning patient is admitted to your PICU after being discovered on the bottom of a murky pool during a children’s pool party. The child was last seen playing poolside ten minutes prior to discovery and was apneic and asystolic at the scene. Bystander CPR was started and paramedics intubated the child and transported him to the Emergency Department. Pupils were fixed and dilated, initial pH was 6.9 and the patient had a pulse of 100 with a blood pressure of 60/palpable on presentation to the Emergency Department after two doses of epinephrine. During the first 24 hours of hospitalization, the patient received an ICP monitor in the operating room, required pressors to maintain blood pressure, and manipulation of the ventilator to maintain oxygenation secondary to presumed aspiration. At the Neurosurgeon’s request, the patient had a CT scan done at 5:00 PM and it is now 7:00 PM. The father wants to know the results.

**PARTICIPANTS:**

Mother, father, doctor, support person, primary nurse

**PHYSICIAN’S TASKS:**

1. Inform parents of patient’s status/CT results.
2. Reconcile parents to receiving the bad news together
3. Explain why information is being channeled through you.

**DURATION ALLOTTED FOR SCENARIO:**

Ten minutes

**BACKGROUND INFORMATION FOR SUPPORT PERSON:**

Social history includes that the parents are divorced and the child normally lives with the father on weekdays and the mother on weekends. They have joint custody. The social worker has alerted you that the child lives with his father and his five uncles. The mother is 18 years old. The father feels that the mother is neglectful.

**SUGGESTED ISSUES DURING MOCK SCENARIO:**

1. Mother: I don’t want you to tell the police anything. I think they blame me.  
Father: I think we need to get DCPS involved.
2. Mother: Why do you have to involve those people? Do you think I could do anything to hurt my baby? I am a good parent.
3. Father: My wife and I are divorced and he is always with me. I want you to tell me all the news first, before you tell his mother.
4. I don’t want you to talk to his mother. She’s no good and hasn’t been around when he’s needed her anyway.
5. Will you tell all my brothers what is going on? I’m not able to at this time.
6. Can I go in and be with my child?
7. Mother: How come someone is in the room with me all the time? Don’t you trust me?
8. I want to go to another hospital for a different opinion.

**BIBLIOGRAPHY – Children and Death****Books for Children before and after the death of a parent or significant other**

- Fassler, Joan. My Grandpa Died Today, Human Sciences Press, 1971  
A book about the love shared by a young boy and his grandfather. When Grandpa died, David as well as the adults cried. In spite of his sadness, David went on playing and eventually learned why Grandpa had not been afraid to die.
- Furman, Ema. A Child's Parent Dies, New Haven and London, Yale University Press, 1974.  
A study of twenty-three children grieving the death of a parent. The children range in ages from fourteen weeks to thirteen years of age.
- Grollman, Earl A. Explaining Death to Children, (edited by Earl A. Grollman) Beacon Press, 1967.  
A collection of articles by different authors pertaining to children and death.
- Grollman, Earl A. Talking about Death: A Dialogue between Parent and Child, Boston, Beacon Press, 1976.  
A book written for parents to read to their children about death. Additional material to aid the parent is included.
- Grollman, Earl A. When Your Loved One is Dying, Beacon Press, 1980.  
A book for older children and adults. You have just learned that someone close to you is suffering from a fatal illness. You are numb with disbelief and overcome by many conflicting emotions. How will you be strong? How can you help?
- Hughes, Phyllis Rash. Dying is Different, Mech Mentor, 1978, (Library of Congress Catalog Number 79-62951).  
Aids children to see death as part of life. Invites questions and exploration. Focuses on increasing the child's awareness of life and death in its most common forms. It is a sensitive and honest introduction to a serious subject for the young child.
- Kubler-Ross, E. On Death and Dying, MacMillan Publishing Company, Inc., 1969.  
For older children. Defines the stages of grief and describes the wide ranges of reactions that both family and patient experience.
- LeShan, Eda. Learning to Say Good-by When a Parent Dies, Avon Publishers of Bard, Camelot and Discus Books, 1978.  
  
Written for the whole family, LEARNING TO SAY GOOD-BY opens the way to genuine communication between youngsters and adults so they can deal with the grief and bewilderment that follows the death of a parent. In simple, direct language, Eda LeShan discusses the questions, fears, fantasies, and stages of mourning that human beings need to go through.
- Mayle, Peter. Will I go to Heaven?, Corwin Books, 1976.  
Peter Mayle helps answer some of the difficult questions children have about what happens after we die.
- Slater, Dr. Robert C. Tell Me, Papa, Centering Corporation, 1978.  
Children have many questions about death. This book takes the great unknown of death and, through the words of Papa, tells it as it is. The feelings that are triggered by death are explained and shared in a loving and caring context. The child will learn that feelings are normal. Feelings hurt but feelings shared are feelings diminished.
- Stein, Sara Bonnett. About Dying, Walker and Company, 1974.  
An open family book for parents and children together. The use of photographs make death very real. This is a book for very young children.
- Watts, Richard G. Straight Talk About Death with Young People, The Westminster Press, 1975.  
The author writes of his experience in discussion groups, with seventh and eighth graders bringing out some of their concerns and fears.

**Pamphlet**

Talking to Children About Death, National Institute of Mental Health, DHEW Publication No. (ADM) 798-838, 1979.

**Books to help children understand death**

Alcott, Louisa May. Little Women

One of the classics about four sisters in which one of them dies.

Brown, Margaret Wise. The Dead Bird. Addison Wesley Publishing Company, Inc. 1938 & 1965.

Describes the physical characteristics of the dead bird and the burial given by the children.

Carrick, Carol. The Accident

Christopher's dog is killed by a pickup truck while they are walking together. The book deals honestly with the boy's feelings of guilt and anger, grief and tears, as he prepares to bury his dog.

DaPaola, Thomas. Nana Upstairs, Nana Downstairs

A sensitive picture book for children who are learning that death is the inevitable end of life. The story describes a young boy's warm relationship with his grandmother and great-grandmother.

Donnelly, Katherine Fair. Recovering from the loss of a Child. McMillan Publishing Co., 1982.

Green, Constance. Beat the Turtle Drum

This book describes the tragedy of an 11-year-old girl's death and its effect upon her older sister and parents.

McNulty, Faith. Woodchuck

This book describes the life of a mother woodchuck and her family during one year, with sketches and simple text. Two of the four young woodchucks are killed by different means during their first year.

Miles, Miska. Annie and the Old One

This story is about a Navajo girl who cannot imagine her world without her grandmother. Annie delays learning to weave from Grandmother because she falsely believes this will keep her Grandmother with her forever.

Schiff, Harriett Sarnoff. The Bereaved Parent. New York: Penguin Books, 1983.

Schiff, Harriet Sarnoff. Living Through Mourning: Finding Comfort and Hope When a Loved One Has Died. New York: Viking, 1986.

Smith, Doris Buchanan. A Taste of Blackberries

This story is about the unexpected death of a friend by anaphylactic reaction to bee stings. Feelings of guilt are looked at in this book.

Smith, Ivan. The Death of a Wombat

The story of a small animal's death in a bush fire has been called many things: an allegorical statement of the human condition, a poignant word picture which sets a standard for imaginative writing, a moving plea for conservation. So vividly is the tale told, the reader feels a terrible, urgent, personal sense of tragedy in the death of this animal.

Viorst, Judith. The Tenth Good Thing About Barney, An Aladdin Book.

The author focuses on the positive things a boy remembers about his dead cat. After the cat's burial in the backyard, the child and his parent reminisce.

Viorst, Judith. Necessary Losses. New York: Simon and Schuster.

**Books for Children Preschool through Grade 8**

- Blume, Judy. Tiger Eyes. New York: Bradbury Press, 1981. (Grade 7+)
- Brown, Margaret Wise. The Dead Bird. New York: Harper Junior Books, 1958. (Grade 3+)
- Buscaglia, Leo. The Fall of Freddie the Leaf. New York, Slack, Inc. 1982.
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**Videos and Software Available**

A Child Dies. American Journal of Nursing – 28 minutes - \$275

Children Die Too. Films for the Humanities and Sciences – 26 minutes - \$149

Requesting Anatomical Gift. American Journal of Nursing – 28 minutes - \$285

Saying Goodbye. Films for the Humanities and Sciences – 26 minutes - \$149

There Was a Child. Fanlight Productions – 32 minutes - \$225

What Do I Tell My Children? Aquarius Productions – 32 minutes - \$150

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Level of Training:	PGY 1 _____	Fellow _____
	PGY 2 _____	Attending _____
	PGY 3 _____	Nurse _____
	PGY 4 _____	S.W. _____

POST-EVALUATION

1. What did you find most helpful?
  - A. Do's and Don'ts List
  - B. Mock Code Case Scenarios
  - C. Video Cases (seeing myself on video)
  - D. Parent Session
  - E. Other \_\_\_\_\_
  
2. What did you feel least helpful?
  - A. Do's and Don'ts List
  - B. Mock Code Case Scenarios
  - C. Video Cases (seeing myself on video)
  - D. Parent Session
  - E. Other \_\_\_\_\_
  
3. Would you recommend this in-service to your fellow staff?
  
4. Do you think you will change your approach to delivering "bad news" based upon what you observed during these sessions?
 

(a) Yes                      (b) No                      (c) Don't Know

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Level of Training: PGY 1 \_\_\_\_\_ Fellow \_\_\_\_\_  
PGY 2 \_\_\_\_\_ Attending \_\_\_\_\_  
PGY 3 \_\_\_\_\_ Nurse \_\_\_\_\_  
PGY 4 \_\_\_\_\_ S.W. \_\_\_\_\_

Six months ago, you participated in a 5-session seminar on "delivering bad news". To evaluate and improve these sessions, we request you return this evaluation form to Dr. Vinay Nadkarni, Division of Pediatric Intensive Care, Alfred I. duPont Hospital for Children, P.O. Box 269, Wilmington, DE, 19899.

### 6 MONTH EVALUATION

1. Have you had the opportunity to be part of a bad news session since completing the "delivering bad news" sessions?
  - A. Primary deliverer of "bad news"?
  - B. Observer of "bad news session"?
  
2. Did you feel you were better prepared?
  
3. Did you find the information we presented in the "bad news" sessions useful?
  - A. What did you find most helpful?
    1. Do's and Don'ts List
    2. Mock Code Case Scenarios
    3. Video Cases (seeing myself on video)
    4. Parent Session
    5. Other \_\_\_\_\_
  
  - B. What did you feel least helpful?
    1. Do's and Don'ts List
    2. Mock Code Case Scenarios
    3. Video Cases (seeing myself on video)
    4. Parent Session
    5. Other \_\_\_\_\_
  
4. How do you feel your real "bad news" session went?  
(a) Outstanding                      (b) Good                      (c) Fair                      (d) Poor
  
5. Did you encounter any of the following questions?
  - (a) Why can't I see my child right now?
  - (b) Why didn't they tell me that at the other hospital?
  - (c) Why can't I smoke? Don't you realize this is the worst thing that's happened in my life?
  - (d) Do you think I could get better care at any other hospital?
  - (e) Will you call my mother with "that" news?
  - (f) Are you the real doctor? You look awfully young.
  - (g) Will my child die?
  - (h) Why do I have to leave while you do that procedure?
  - (i) My child is so sick, can't both of us stay in his room with him? Neither of us wants to be alone.
  - (j) What would you do if it was your child?
  - (k) Did my child suffer any pain?
  - (l) Other: \_\_\_\_\_
  
6. Would you recommend the "bad news" in-service to your fellow staff?  
(a) Yes                      (b) No
  
7. Do you feel attending this in-service on "Ways to Delivering Bad News" changed the way you conduct "bad news" sessions now?  
(a) Yes                      (b) No

## **10 Commonly Asked Questions by Physicians**

1. What if I feel like crying.
2. Should I go to the funeral?
3. If I feel like the patient did suffer, should I tell the parents if they ask?
4. Should I use the word “died” or “passed away” or “expired” or “lost”?
5. What should I say if I run into the parents of a patient who recently died – should I say anything about the deceased child?
6. Should I give this “news” over the phone?
7. Should I discuss the “news” with family members?
8. Should I “volunteer” what I would do, if it were my child?
9. If one person runs out of the room, should I go after them?
10. How long should I wait after giving “death news” before I start explaining “what happened”?

## **Suggested Responses for Facilitators**

1. It’s okay to cry. Families feel closer. It says to them that their child was more than just another case to you. Remember “appropriate affect”.
2. The family appreciates the attendance of the medical personnel. They often comment about how important it is to them, especially if there has been an ongoing relationship. It’s recommended to attend, especially if “you” feel the need. It’s the natural progression.
3. Remember, family members’ main concern is “did they suffer?”. It depends on your level of comfort. People will sense if you are not telling the truth. This is a judgment call for yourself, however comfortable you are with the issue.
4. Always use the red flag words “die”, “died”, “killed”, “cancer”, “tumor”. Licenses expire, not people. These words help reinforce the facts as people are usually in a state of shock after being given bad news.
5. Always acknowledge these people. You can use phrases such as “how are you”, “I was just thinking of you”, or “I’ve been wondering how you’ve been”. The person will take it from there. If they want to bring up the deceased, they will, especially if you appear interested and not overly anxious.
6. If at all possible, try not to give information over the phone. If you have no choice, try to see if you can get a neighbor there or a police officer or a family member. It’s important that the person has transportation available to them to get safely to the hospital.
7. Make sure to ask the parents if it is okay if you speak with other family members. Only offer if you are going to be available to do so.
8. If the family solicits the input of the doctor and if you feel comfortable, share with them. But to offer your opinion is a judgment call and most families do not desire unsolicited input.
9. If a person leaves the session upset, it’s important for “someone” to check on that person. It should be either the support person you have with you or another family member, and you might solicit someone to do this; e.g. “Would you make sure she’s okay?” It’s not appropriate for the person who is giving the news to run after that person.
10. Timing is important. If you take a minute and reflect upon what is happening, look around. It will seem like forever but, in fact, it is usually only a minute or two until someone will look up and ask. For example, “What happened” and this is your chance to go on with the information.