SHORT REPORT

Specialist registrars' emotional responses to a patient's death

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Aim: To investigate the emotional reactions of registrars following the death of a child.

Methods: A multicentre study to determine the sources of support for registrars and the use of debriefing following a child's death. A questionnaire was sent or given to registrars within the South West Region.

Results: There was a 75% response rate; 71% of registrars felt they had initial support but limited ongoing support and 69% of registrars supported junior colleagues. There was debriefing in 31% of cases.

Conclusions: More accessible and constructive support for staff needs to be developed following a patient's death.

Dealing with the death of a child can be especially difficult. There is little written on the grief responses and coping mechanisms used by doctors at these times. A recent paper from the USA¹ on doctors' emotional reactions to an adult patient's death concluded that a "conspiracy of silence toward emotions can potentially cause trainees to develop maladaptive coping patterns that lead to burnout and other forms of emotional distress." Our study sought to explore paediatric registrars' emotional reactions to a patient's death.

METHODS

A self administered questionnaire (with one reminder) was sent or given to registrars within the South West Region. The study was approved by Bath local research ethics committee. The questionnaire was initially piloted on a group of registrars as part of a teaching session and subsequently redesigned in response to their feedback.

RESULTS

We had a 75% response (42/56). Most registrars had been involved in a child or neonatal death within the previous six months. The results are given in table 1.

Debriefing

Registrars had mixed experiences of debriefs. Good points included: "time to reflect and support each other", "raise learning points for the future", "opportunity to grieve and find out how others feel". Negative points included: "turned into a finger pointing exercise", "felt quite vulnerable to raise things", "too many people there (15–20)", "disagreements arose because of too many strong personalities in room". One registrar felt very strongly "attending a debrief should be as standard as filling out a death certificate". Registrars felt debriefing should "provide an opportunity to resolve worries"; "discuss insecurities"; "offload experience"; "share emotions" and "get reassurance that everything was done". Registrars felt the chair was key to success: "someone able to see the bigger picture and provide a structured approach".

Do you still think about unresolved issues relating to the death?

Registrars think about their involvement: "I felt like the grim reaper when asked to pull out the ET tube", and many have issues of self doubt, "was everything humanly possible done?" or "I still wonder if a more experienced doctor would have saved the child". They also remember the family: "I wonder how they are coping and how I would manage in the same circumstances, ... how precious the lives of my children are", "we withdrew care...he looked perfect. It was difficult to believe that this was the correct course of action".

Is there a particular baby or child who died who you still think of? If so why?

Some felt that they remembered all the children who had died. Other deaths are remembered because they were shocking: "we had to open his chest...it was so brutal – an awful death that will stay with me", "the first time I confirmed death in a child", "horrific circumstances dealt with alone". Many memories relate to Christmas: "it was before Christmas and I kept thinking of the unopened presents." Registrars consider their own families: "an asthmatic who looked like my 5 year old – it seemed so awful they could die so quickly", "since having my own children, death is much harder to cope with". Some remember children because of their courage "several who have been brave...yet determined to 'live' until they died".

DISCUSSION

A child's death is tragic—"it is unnatural and untimely for the beginning and end of a life to occur within hours, days or months of each other".² Many registrars initially deal with this situation with limited support. In this study 71% felt they had some initial support but only 29% said they were offered ongoing support at work and were therefore turning to their partner or friends for support. Writing about SIDS Mandell³ found that 81% of doctors needed someone to talk to about death and experienced feelings of self doubt, inadequacy and guilt. Raj Persaud also stresses the importance of "ventilation and validation",⁴ and previous studies have found that support from work related sources are more beneficial than outside sources.⁵

Following a child's death 69% of registrars supported junior colleagues and nursing staff. Experienced paediatricians find these situations difficult too, and one registrar wrote referring to the consultant "we supported each other". Only 52% felt they were able to give adequate support to others, either because they "didn't know how" or because they were too busy. Staff need support and encouragement to continue providing high quality care and over time their resources to deal with dying infants and children may be depleted.⁶ In our study no registrar had experience of talking to a counsellor for support, but 30% said they would consider talking to a counsellor if available, while 24% said they would not.

Table 1 Responses from registrars to questionnaire about child deaths

Question	Answer (n (% responding))*
Regarding the last death you were involved with:	
Did the death happen out of hours?	Yes, 29 (69%); No, 13 (31%)
Were you the only senior doctor involved?	Yes, 9 (21%); No, 33 (79%)
What happened afterwards? (did you have time to reflect or did you have to get on with other jobs?)	No time for reflection, got on with other jobs, 23 (55%) Short time to reflect, 11 (26%) Long enough to reflect, 4 (9.5%) Went home at end of shift, 4 (9.5%)
What would you have liked to happen afterwards?	More time to reflect before work, 24 (57%) Happy with the way things happened, 6 (14%) (short time to reflect, 2; long enough to reflect, 2; went home, 1; got on with other jobs, 1) Unsure, 2 (5%) More parental support, 1 (2%) More discussion with consultant, 2 (5%) Left blank, 7 (17%)
Did you need to support colleagues after the death?	Yes, 29 (69%); No, 13 (31%) (nurses 62%, SHOs 51%, specialist registrars 8%, midwives 8%, A&E staff 6%, consultant 3%)
Did you feel able to give the support they needed?	Yes, 15 (52%) No, 9 (31%) – too busy Don't know, 4 (14%) – “don't think I did a good job”
Did you receive support from anyone?	Yes, 30 (71%) (consultant 50%, specialist registrar 5, SHO 3, nurse 10, midwife 2%, chaplain 1, husband 1, parents of child 1)
Was ongoing support offered to you?	Yes, 12 (29%); No, 30 (67%); left blank, 2
Who did you talk to about the death?	Consultant 76%, nurse 67%, SpR 43%, SHO 33%, chaplain 5%, counsellor 0% Partner 69%, friends and family 50%
If you spoke to someone following the death was it useful?	Yes, 37/41 (90%) Unsure, 3/41 (7%) No, 1 – “death is part of life; we treat it as something that should not be mentioned”
Considering debriefing:	
Was there a formal debriefing following the last death you were involved with?	Yes, 13 (31%); No, 28 (67%); left blank, 1
Would it have been useful?	Yes, 22/28 (79%); Unsure, 6/28 (21%)
Have you been involved in a debriefing before?	Yes, 32 (76%); No, 10 (24%)
With regard to deaths in general:	
Do you still think about unresolved issues relating to the death?	Yes, 17 (41%); No, 22 (52%); Unsure, 2 (5%); Left blank, 1
Is there a particular baby or child you still think of?	Yes, 38 (91%); No, 4 (9%)
With regard to training:	
Have you had any recent training in breaking bad news? (since medical school)	Yes, 25 (59%) Not since medical school, 11 (31%) No, 6 (14%)

*Total n = 42 unless specified.

Fifty five per cent felt they had no time to reflect afterwards; 57% would have liked longer to reflect before getting on with work. The fast pace of work allows little opportunity for registrars to process their feelings before they move on to the next patient. Clearly the ability to support and feel supported is linked to the time available. On a busy shift, out of hours, time is limited.

In this study there was a debrief in only 31% of cases, although 79% felt that debriefing would have been helpful to deal with the “fallout” from a child's death. Debriefs were often arranged on an ad hoc basis with some registrars being unable to attend. Research has shown that it is beneficial to assist staff in dealing with their emotions and to provide an atmosphere that promotes the mourning process.⁷ A debrief is one way of initiating the process. However, it must be noted that little work has been done to evaluate their use formally in this situation. Most studies have looked at critical incident stress debriefing involving emergency services,

including the use of debriefs in preventing post-traumatic stress disorder, where their effectiveness has been questioned.⁸ More research is needed.

When asked about training, some registrars felt that more is gained from experience and “seeing it done” rather than theoretical study days. However, as 21% of registrars were the only senior doctor involved and 59% spoke to parents alone with no consultant involvement, it may be difficult to improve hands-on learning in this situation. Study days involving role play of scenarios using actors could bridge this gap and allow these difficult situations to be portrayed.

When an infant dies “grief may overwhelm not only the parents but the physician.”³ Behnke⁹ surveyed 25 paediatric house officers and found their grief reactions similar to the death of a loved one, also emphasising that there is little written on doctors' coping mechanisms. Registrars in this study were frank about their experiences. Some found expected deaths “less shocking” and “more emotional but

easier to resolve", others commented that there was "almost a sense of relief which makes it more bearable". Experience varied: "when you know the family it hits you less hard initially but....stays with you longer", "I am surprised at my own emotional fragility even when it is expected". Unexpected deaths seemed to "hit us harder" and "difficult because of sheer rush of events", "I found the families grief unbearable even if I have never met them". This is another area which training days could focus on as it has been well documented that families "express with vivid clarity the details and memories surrounding their child's death, specifically the actions and attitudes of staff".¹⁰

Ninety one per cent of registrars think of a particular baby or child who died. Many of these thoughts relate to doubt regarding management and unresolved issues. Some registrars do have positive memories and remember "those I knew well and prepared for" and those children "who have been brave".

Many registrars said that a child's death made them reflect on their own children. Registrars commented "sudden deaths are much harder, this could be your own child – therefore more shocking". The death of a patient often triggers the registrar to value "how precious my children are". Several registrars continued to be affected by children's deaths, particularly when of a similar age to their own. One involved in a cot death visualised their own child dead weeks later, another was given a Babygrow for her baby that was the same as one worn by a patient who died.... "I couldn't put her in it....I still have it".

As health professionals we need to develop insights into the "sudden intimacies with strangers" – those moments when the "human barrier cracks open to reveal what is secret and inarticulate".⁸ The challenge now is to provide accessible, acceptable, and constructive support for staff during these times.

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