

# **Delivering the News With Compassion**

The GRIEV\_ING<sup>®</sup> Death Notification Protocol

## **Trainer's Manual**

© 2005 **Cherri Hobgood, MD**

This project was supported by Grant No. 2005-VF-GX-K021 awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. Points of view in the document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

# TABLE OF CONTENTS

<b>I. TRAINING OVERVIEW</b>		page 3
<b>II. HOW TO CONDUCT THE GRIEVING DEATH NOTIFICATION TRAINING</b>		page 4
<b>III. TRAINING MATERIALS</b>		
◆ Self-Efficacy (Confidence) Survey	Attachment A	page 8
◆ PowerPoint Presentation for First Mini-Lecture	Attachment B	page 9
◆ PowerPoint Presentation for Second Mini-Lecture	Attachment C	page 14
◆ Role Play Scenarios (Three)	Attachment D	page 17
◆ Guidelines for Training Standardized Patients	Attachment E	page 23
◆ Standardized Survivor Scenarios (Three) <ul style="list-style-type: none"><li>▪ Scenario A: Death of a 12-year-old grandchild</li><li>▪ Scenario B: Death of an elderly widow after a robbery and beating</li><li>▪ Scenario C: Death of a 16-year-old exchange student in a DUI accident</li></ul>	Attachment F	page 24
◆ Additional Cases for Development	Attachment G	page 39
◆ Template for Developing Standardized Patient Scenarios	Attachment H	page 41
◆ GRIEVING Competence Instrument <ul style="list-style-type: none"><li>▪ Long Form (27 items)</li><li>▪ Short Form (11 items)</li></ul>	Attachment I	page 46
◆ Relationship and Communication Instrument	Attachment J	page 49

# TRAINING OVERVIEW

## WHY THIS TRAINING IS IMPORTANT

- ◆ Death notification is a common, difficult, and emotionally laden communication for emergency physicians.
- ◆ Teaching emergency medicine residents the skills for success in this communication is an important focus for educators.
- ◆ To accomplish this task, educators need practical, proven teaching and assessment tools focused on death notification skills.
- ◆ A defined educational intervention focused on the GRIEV\_ING mnemonic can improve physician confidence and competence in death notification.

## INTENDED AUDIENCE

This training is designed specifically for residents in departments of emergency medicine. However, it may be adapted to other groups of learners.

## OBJECTIVES OF THE TRAINING

Learners will be able to:

- ◆ Communicate using empathic skills
- ◆ Organize death notification using the “GRIEV\_ING” mnemonic
- ◆ Perform an effective death notification using “GRIEV\_ING.”

## WHO DEVELOPED THE TRAINING

The GRIEV\_ING Death Notification Model and the training design were developed by Cherri Hobgood, MD, Associate Dean for Curriculum and Educational Development, Director of the Office of Educational Development, and Associate Professor of Emergency Medicine at the University of North Carolina School of Medicine.

This manual was prepared at the University of North Carolina School of Medicine, Office of Educational Development, by Katherine D. Savage, MA, Faculty Development Consultant, and Susan Sawning, MSW, Project Manager.

# HOW TO CONDUCT THE GRIEVING DEATH NOTIFICATION TRAINING

## PREPARING FOR THE TRAINING

1. **Arrange logistics** (date, place, time, number of participants).
2. **Contact local social service and victim service programs** to verify the types of services that are available to survivors in your area.
3. **Arrange for materials and equipment.**
  - ◆ Laptop computer and projector
  - ◆ Copies of all materials to be used by participants
    - Self-efficacy surveys
    - Role play scenarios
    - Simulated Survivor scenarios for residents
    - GRIEVING pocket card: include, on back of card, information about resources in your locale
    - Assessment instruments for Standardized Survivors to use
4. **Recruit and train standardized patients for roles as standardized survivors.** See **Guidelines for Training Standardized Patients, Attachment E.**

## THE SESSION

### Activity 1: Introduction

5 minutes

**Introduce yourself** and ask participants to complete the **Self-Efficacy (Confidence) Survey** before beginning your presentation. **This survey is Attachment A.**

### Activity 2: Mini-lecture/PowerPoint Presentation #1

10 minutes

Using the PowerPoint slides, present the **first mini-lecture**, which will include the Introduction, Rationale for the Training, Objectives, and Empathic Communication Skills. The PowerPoint presentations provide the essential information to be shared with the residents in the large group sessions. The final slides of each presentation announce a small group activity. **The first mini-lecture is Attachment B.**

### Activity 3: Structured Discussion

20 minutes

- The first small group activity is a **structured discussion**. Divide residents into groups, with the size of groups determined by the time available for both small group and large group debriefing.
- **Give the following instructions to participants:** Take a moment or two to think about the following questions. Discuss your thoughts on these questions with other members of your small group. Use empathic communication techniques to facilitate discussion within your small group. Try to be as open and honest as possible about the things that have helped you deal with difficult news in the past. Be prepared to share a summary of your group's discussion with the large group at the conclusion of this session.
- **Questions for the groups:**
  1. Can you remember a time in your life when you lost something precious or important to you?
    - a. What did you need to hear at that time?
    - b. What didn't you need, or want, to hear?
  2. Do you *specifically* remember a time when you learned difficult or sad news?
    - a. What things were helpful to you?
    - b. What things seemed wrong? Or made learning the news more difficult?
    - c. Do you recall specific communication skills that were effective? Ineffective?
  3. Do you consider a failed resuscitation a personal failure as a physician? Why or why not?
  4. Do you ever feel "helpless" or "unempowered" when delivering a death notification?
- **Optional question:**

Group leaders, use this question at your discretion if you feel the group can move forward into this discussion. It is central to how many people deal with death notification, but may be difficult to explore in the time allotted.

  5. Have you ever thought about your death? How does this fit into your paradigm of a physician?

#### **Activity 4: Mini-lecture/PowerPoint Presentation #2**

**10 minutes**

Using the PowerPoint slides, give the **second mini-lecture**, which teaches the GRIEV\_ING mnemonic. **The second mini-lecture is Attachment C.**

#### **Activity 5: Break**

**5 minutes**

Give participants a 5-minute break between the second mini-lecture and the second small group activity.

#### **Activity 6: Paired Role Plays**

**35 minutes**

- Working in triads, each person will have the opportunity to play the physician, the survivor, and the observer of the interaction, switching roles as she/he moves through the three cases. **Three role play scenarios are in Attachment D.**

- **Roles**

*Physician:*

In the physician role in one of the practice mini-cases provided, use the skills of empathic communication and the GRIEV\_ING mnemonic to deliver the death notification to the survivor.

*Survivor:*

React to the news provided by the physician as if you were the survivor described in the case.

*Observer:*

Use the GRIEV\_ING Competence Short Form as a checklist as you observe the physician's skills. You may also take brief notes. Be prepared to make suggestions for improvement.

- **Instructions**

1. Choose roles for the first role play.
2. Role play for 3 to 5 minutes.
3. After completing the role play, allow the physician to critique him/herself first, then the survivor, then the observer.
4. Repeat for the second and third role plays, taking a different role for each scenario.

## Activity 7: Authentic Assessment

30 minutes

- The final activity for teaching and assessment will use Standardized Survivors (Standardized Patients playing the role of survivors).  
See **Guidelines for Training Standardized Patients, Attachment E**.
- Three scenarios are provided for this activity. You may choose to have all Standardized Survivors portray the same scenario if your group is large and each resident is to be assessed only once. Or if you extend the time for the last activity and each resident will have the opportunity for more than one Standardized Survivor encounter, you may train the “survivors” for several scenarios. Time available, the number of residents, and the number of available Standardized Survivors will determine how many scenarios you use. However, every resident should participate in identical scenarios for purposes of comparison.
  1. **Three complete scenarios are in Attachment F.**
  2. **Additional cases for development are in Attachment G.**
  3. **A template for developing Standardized Patient scenarios is Attachment H.****Attachments G and H** are tools for trainers who wish to develop new cases.
- Each Standardized Survivor encounter should take place in a separate, private room. Information for the resident in the case should be posted on the door of each room. When every resident has completed reading the update, all should enter their rooms at the same time for each 15-minute encounter. A resident who completes the death notification in less than 15 minutes may leave the room, but no one may exceed the 15-minute limit. **Remind residents to stay in role throughout the encounter.**
- After the resident leaves the room, the Standardized Survivor should complete the Relationship and Communication Instrument and the GRIEV\_ING Competence Instrument. **\*Note:** If you are able to observe the encounters (for example, reviewing videotapes of the residents with standardized survivors), you may directly score the GRIEV\_ING Competence Instrument.  
**Assessment instruments are Attachment I (Relationship and Communication Instrument) and Attachment J (GRIEV\_ING Competence Instrument).**

## Activity 8: Self-Efficacy Survey

5 minutes

Ask residents to complete a second copy of the Self-Efficacy (Confidence) Survey at the end of the session. **This survey is Attachment A.**

# ATTACHMENT A

## SELF-EFFICACY (CONFIDENCE) SURVEY

**Directions:** For each item below, indicate how confident you are in your ability to perform that activity in an encounter with a survivor(s). Indicate your confidence level with the appropriate number from 1 to 5, with 1 indicating a complete lack of confidence and 5 representing complete confidence.

**SCALE:** 1–Not at all 2–slightly 3–somewhat 4–mostly 5–completely

*How confident are you in your ability to....*

- \_\_\_1. Ensure that all important survivors are present prior to your delivery of the death notification?
- \_\_\_2. Identify and utilize support resources to assist survivors during a death notification?
- \_\_\_3. Introduce yourself to survivors and explain your role in the preceding events?
- \_\_\_4. Determine the survivors' understanding of the patient's condition before you inform them of the patient's death?
- \_\_\_5. Inform and educate survivors about the death of a loved one?
- \_\_\_6. Verify for the survivors that the patient has died by using unambiguous phrases like "is dead"?
- \_\_\_7. Identify survivors' need to take an emotional break?
- \_\_\_8. Determine if the survivors need further information about the patient's death?
- \_\_\_9. Present survivors with information on organ donation, funeral services, and disposal of the patient's personal belongings?
- \_\_\_10. Identify yourself as a resource to the survivors and provide your contact information to them after a death notification?



## Attachment B

## GRIEV\_ING

A Tool to Improve  
Death Notification

Copyright 2005  
**Cherri Hobgood, MD**

Associate Dean  
Curriculum and Educational Development  
Department of Emergency Medicine  
University of North Carolina

## GRIEV\_ING Objectives

Learners will be able to:

- Communicate using empathic skills
- Organize death notification using the GRIEV\_ING mnemonic
- Perform an effective death notification using "GRIEV\_ING"

## US Deaths

- Common occurrence
  - ◆ About 1 million in-hospital deaths annually
  - ◆ In 2002, there were more than 272,000 ED deaths
- High risk
  - ◆ Significant source of family dissatisfaction
  - ◆ Management of the death is a major determinant in malpractice litigation

## Pediatric Deaths

- 40,000 children age 14 and under die each year
- 20% (8,000) die or pronounced dead in outpatient sites, primarily the ED

## Why do we care?

- All of us will care for dying patients and their families
- At the end of life, there is no second chance to get it right

## Ideal World

- Ongoing **Relationship** with the patient and family
- Death expected with time to **Emotionally Prepare**
- Physician has **Education and Expertise** in the delivery of death notification

## The Intern's World

- Often no significant relationship with the patient or family
- Sudden and **unexpected death**
- Death after an emotionally exhausting **failed resuscitation**
- **Little education** to prepare us to deliver this devastating news

## Our World

- Variables are often out of our control
- Create significant stress for physicians
  - ◆ Emotionally draining
  - ◆ Dealing with death is a major cause of physician and staff disillusionment

## Their World

- Stressful for family members
  - ◆ Limited psychological preparation
  - ◆ They do not know you
  - ◆ Have little or no contact with you afterward
  - ◆ Increased rate of pathological grief reactions
    - ◆ Intense grief
    - ◆ Prolonged mourning
    - ◆ Increased morbidity and mortality

See one,  
Do one,  
Teach one.

Should not apply here

## Empathic Communication

### Empathic

Characterized by or based on empathy

### Empathy

1. Projection of a subjective state onto an object
2. Capacity for participation in another's feelings or ideas

*Webster's New Collegiate Dictionary*

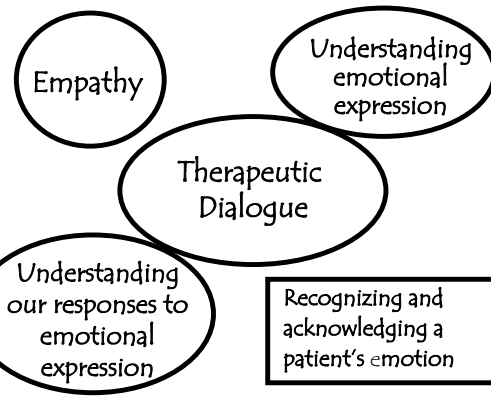
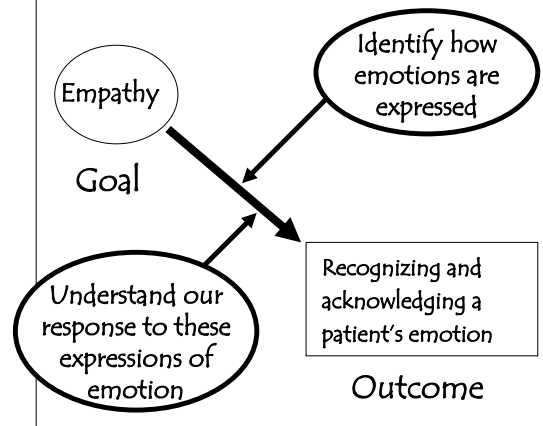
## Empathic Communication

### Two Components

- Cognitive
  - ◆ Accurate understanding of the patient's feelings
- Behavioral
  - ◆ Effective communication of that understanding to the patient

## Empathic Communication

- Empathic Opportunity
  - ◆ Directly expressed emotion by a patient
- Empathic Response
  - ◆ Expressed recognition of the patient's emotion
- Empathic Terminator
  - ◆ Directing the patient away from the stated emotion



## Emotional Expression

- |                    |                     |
|--------------------|---------------------|
| ■ Crying           | ■ Antagonism        |
| ■ Anger            | ■ Hostility         |
| ■ Numb, just blank | ■ Complete collapse |
| ■ Incomprehension  | ■ Hysteria          |
| ■ Blame            | ■ Wailing           |
| ■ Denial           | ■ Fear              |
| ■ Guilt            | ■ Prayer            |

The Range of Emotional Responses Is Wide  
so  
Expect Anything and Everything

## Physician Responses

- Withdrawn
- Clinical
- Distant
- Fear
- Sorrow
- Antagonism
- Defensive
- Understanding
- Empathy
- Concern
- Curt
- Unflappable
- Brave
- Indifferent

## How would you act if.....

- Your next door neighbor came over to tell you he had cancer?
  - ◆ Pull up a chair and sit down
  - ◆ Listen
  - ◆ Express sympathy and concern
  - ◆ Offer to help in any way you could

## Why should we act differently at work ?

### Misconceptions of the Professional Role

- ◆ Know what to do and say in every situation
- ◆ Consistently unflappable and brave
- ◆ Basic human resources and vocabulary unavailable
- ◆ Unable to express human sympathy
  - ◆ Diminishes our professional role

## "I'm sorry"

- Two types
  - ◆ Sympathy
  - ◆ Apology and acceptance of responsibility
- Use phrases that express.....
  - ◆ Your feelings
    - ◆ "I am sorry for your loss"
  - ◆ Your acknowledgment of their feelings
    - ◆ "I see that it is difficult to accept the loss of your mother"

Listen

## Three Rules of Listening

1. Assume an attentive posture
2. Let people speak
3. Then show them you heard

### 1. Assume an attentive posture

- Introduce yourself
- Shake hands
- Sit down at matching eye level
- Lean forward, hands on the knees

### 2. Let people speak

- Factoid
  - ◆ Average time patient is allowed to speak uninterrupted by a physician is 18 seconds
- Use open questions and verbal cues to encourage their expression
- Tolerate brief periods of silence

### 3. Then show them you heard

- Repetition
  - ◆ Use one or two of their key words
- Reiteration
  - ◆ Paraphrase what they have said
- Reflection
  - ◆ Interpret and listen for the hidden
- Respond

## Small Group Session I

# Attachment C

## What is "GRIEV\_ING"

- Tool to assist you
  - ◆ An information and organizational prompt
  - ◆ Allows you to ensure accurate and complete information transfer
  - ◆ Frees you to attend to the empathic portions of the communication

- G gather
- R resources
- I identify
- E educate
- V verify
- \_ space
- I inquire
- N nuts and bolts
- G give



## GRIEV\_ING

### G – Gather

- The family or survivors
  - ◆ Ensure that all members are present
  - ◆ Offer to call others or wait if other family members will be arriving soon

## GRIEV\_ING

### R – Resources

- Call for support resources available to assist the family with their grief
  - ◆ Hospital chaplain services
  - ◆ Family minister
  - ◆ Family and Friends
  - ◆ Interpreter
  - ◆ Victim Services/Bereavement Support

## GRIEV\_ING

### I – Identify

- Yourself and your role
- The deceased patient by *name*
- The family's state of knowledge about the events
- That you are bringing **BAD NEWS**
  - ◆ Fire the *Warning Shot*

## GRIEV\_ING

### E – Educate

- The family
  - ◆ Start from where they ended their story
  - ◆ If possible, use their terms
  - ◆ Avoid jargon
  - ◆ Use slow and steady steps
  - ◆ If needed, fire another warning shot
  - ◆ Check their comprehension frequently

## GRIEV\_ING

### V – Verify

- Their family member has died
- **Be clear!** Do not use euphemisms
  - ◆ “Passed away”
  - ◆ “No longer with us”
- Use the words “dead” or “died”

## GRIEV\_ING

### \_ Space

- Give the family personal space
- Emotional moment
- Registration of information
- Tolerate silence
- Touching is OK
- Give them permission to cry

## GRIEV\_ING

### I – Inquire

- Ask if there are any questions
- Answer them all
- Assess understanding
  - ◆ Elicit summary statements from them
  - ◆ Listen for the hidden question

## GRIEV\_ING

### N – Nuts and Bolts

- Inquire about organ donation
- Funeral services
- Personal belongings
- Offer the family the opportunity to view the body

## GRIEV\_ING

### G – Give

- Give them your card and contact information
- Offer to answer any questions that may arise later
- Always return or take their call
- Offer information about local resources

## Policies

- Hospital specific
- Know your hospital's policies for
  - ◆ *Reporting deaths to the ME*
  - ◆ *Discussing organ donation with family*
  - ◆ *Calling your state's organ procurement association*

- G gather
- R resources
- I identify
- E educate
- V verify
- \_ space
- I inquire
- N nuts and bolts
- G give



**Delivering the News With Compassion**  
The GRIEV\_ING Death Notification Protocol

<b>G</b>	Gather all family members
<b>R</b>	Resources such as chaplain services, family, and friends
<b>I</b>	Identify yourself, name of deceased or injured patient, and state of family's knowledge of events of the day
<b>E</b>	Educate family about events that occurred in ED, and current state of loved one
<b>V</b>	Verify that loved one has died, use "Dad" or "Dad"
<b>_</b>	Give them <b>SPACE</b> and <b>TIME</b> to absorb the information
<b>I</b>	Inquire if there are questions, and attempt to answer them
<b>N</b>	Nuts and bolts, ask about organ donation, funeral services, parental belongings, offer family opportunity to view the body
<b>G</b>	Give them your card with your contact information, offer to answer questions that may arise later, and always return their call

Death Notification Card 2 (2018) © 4/2018 1.01.13.158

**Local Resources**

Chaplain Services	_____
Social Services	_____
Organ Donor	_____
Medical Examiner / Coroner	_____
Police	_____
Funeral Homes	_____
MADD Helpline / 1-877-MADD-HELP / 1-877-622-3429	_____
Victim Services	_____
Other Resources	_____

Death Notification Card 2 (2018) © 4/2018 1.01.13.158

"Life is short, the art long,  
experience treacherous,  
judgment difficult"

*Hippocrates*

Small Group Session II



## Small Group Session II

- Structured role play
- Three cases
- Everyone will play each role
  - ◆ Physician
  - ◆ Family member
  - ◆ Observer
- Feedback given to physician in every cycle
  - ◆ Be accurate and specific
  - ◆ Scoring guides provided

# ATTACHMENT D

## ROLE PLAY SCENARIOS

### CASE 1

**Role:** *Physician* in charge of resuscitation

Harvey Edwards is a 1958 Carolina graduate who has returned for his class reunion and a football game. His long-time friend and college roommate, James Smith, with his wife, Ellen Smith, accompanied him. As they were walking to their car in the hotel parking lot Friday night, they were approached by a young man armed with a handgun who demanded Mrs. Smith's purse and Mr. Edwards' and Mr. Smith's wallets. Mr. Edwards began to shake and had difficulty removing his wallet from his pocket, whereupon the robber struck him on the head with the handgun and fled. Mr. Edwards collapsed, 911 was called, and he was transported to the ED. Immediately upon arrival at the ED, he arrested. A prolonged attempt at resuscitation fails.

You must notify any survivors of his death.

## CASE 1

**Role: Survivor:** Mr. James Smith, a chemist who developed a Velcro-like product and is a *huge* supporter of the university.

**Relationship:** Long-time friend and college roommate of the deceased patient, Harvey Edwards.

**Concerns:** Mr. Smith is extremely distraught after having seen his old friend collapse in the midst of a mugging. He feels that he, his wife, and his friend were helpless victims of a crime, yet at the same time, he blames himself for not having done anything to intervene and save his friend from being attacked. He is very concerned that Mr. Edwards' wife had been unable to accompany him to the reunion weekend (she is helping their daughter with a new baby) and is currently unaware of her husband's condition. He has tried her cell phone number several times but has gotten no answer.

Upon learning of Mr. Edwards' death, Mr. Smith has three major concerns: first, that the information about Mr. Edwards' death be conveyed to Mrs. Edwards as rapidly as possible. Second, he is anxious that she not learn of her husband's death in an impersonal manner. Third, he is fearful that he will be unable to convey all the information about the events of the evening accurately to law enforcement personnel.

Mr. Smith has Mrs. Edwards' cell phone number. He knows that Mr. Edwards had a long and significant cardiac history and a significant but distant history of tobacco use.

## CASE 2

**Role:** *Physician* in charge of the resuscitation

The patient is a 32-year-old police officer, Joy Pruitt, who was involved in a head-on collision while chasing a drunk driver. There was a prolonged extrication with significant intrusion into the driver's space. The patient was transported with known pelvic and left femur fractures and a distended tense abdomen. She arrested once en route, and CPR was in progress when she arrived in the trauma room. After administration of 15 units of fluid, 5 units of blood, 3 units of FFP, bilateral chest tubes, and re-warming, the patient dies.

Her captain is in the ED when you emerge from the trauma room and informs you that she has three small children at home and that her husband is in the waiting room.

## CASE 2

**Role: Survivor:** Mr. Joe Pruitt, a 35-year-old construction worker and 10-year husband of Joy. Joe is the father of their three small children, ages 8, 6, and 4.

**Setting:** He has been escorted to the ED from the construction site by a member of Joy's squad. The children are in daycare. He knows there has been an accident but does not know how severe it was. He has been waiting for more than 20 minutes with no information. He has delayed calling Joy's mother until he has news about Joy's condition.

He and Joy recently bought a house, and both of them have been working extra hours to pay for the expense of moving. She picked up this shift today at the last minute.

He wants desperately to get back to see his wife.

## CASE 3

**Role:** *Pediatric attending* in the ED

The patient is a 3-year-old boy, Michael O'Connor, who was brought into the ED after being pulled from a horrific house fire. He was found trapped under collapsed debris and was burned over 70 percent of his body. Despite efforts to sustain life, he died from his injuries.

His father, Michael O'Connor, Sr., has been shouting loudly at the ED staff, demanding his rights and threatening lawsuits. You must inform him that his son is dead.

### CASE 3

**Role:** *Survivor:* Mr. Michael O'Connor, Sr.

**Relationship:** Father of Michael O'Connor, Jr.

**Demeanor:** The father appears angry and hostile. He is unaware that his son is dead, only that he has taken a "turn for the worse." He has been shouting loudly at the ED staff, and threatening lawsuits against the fire department, the hospital, and everyone who gets near him.

**Concerns:** After a fight with his wife, Mr. O'Connor drank heavily earlier in the evening until he passed out on the sofa in the living room. He was awakened by his wife screaming that the house had been struck by lightning and that the upper floor was in flames. While she ran next door for help, Mr. O'Connor tried to fight his way up the staircase to the bedroom where his 3-year-old son was sleeping, but the smoke and flames were too intense. He stood outside helplessly while the fire department fought the fire. Firefighters who made their way into Mikey's bedroom found him beneath collapsed debris, badly burned but still breathing.

Mr. O'Connor is certain that if he had not fought with his wife and gotten drunk, he would have been able to respond quickly and save his child.

# ATTACHMENT E

## GUIDELINES FOR TRAINING STANDARDIZED PATIENTS

Standardized Patients (SPs) are “patient actors” trained to portray a case scenario to assist in teaching and evaluating health professions students. SPs are recruited for a case based on applicable demographics, which can include ethnicity, gender, language, weight, and/or anything else that fits into the case description, keeping it realistic and on track to meet the set objectives.

A training session for SPs generally begins by covering all administrative aspects (using a PowerPoint presentation or verbally): payment timesheets, working schedules, and an overview of the program they are training for. Reliability is critical for a successful SP exercise, and this point is brought up consistently during the 2+ hour session. A printed copy of the case scenario is given to the SP. Everyone reads along together, and there are pauses for questions throughout. A case scenario typically gives a background story, a family medical history, an individual social and medical history, and a presenting complaint. The SP is required to memorize all details of the case in order to accurately answer questions with “standardized” responses. Following the case review, SPs are given a chance to ask/pose questions that might be asked for which the scenario does not contain answers. For those questions, a standardized response can be created, but generally SPs are allowed to answer using their own experiences as long as their responses do not conflict with elements of the case scenario.

SPs then go over the mechanism (if applicable) of evaluation/feedback for the encounter. They must learn the checklist of competencies including relationship and communication items and what those mean. Next, SPs take turns acting the role of the patient and/or student/resident while the group rates by using the evaluation scales. As a group, the answers are compared with the trainer’s to test interrater reliability and formulate a standard of scoring. Additional questions can be answered at this point, also. If available, a gold standard video can now be played showing the case and allowing the SP another chance to practice scoring. Because the trainer knows exactly what scores this video should receive, it is very easy to identify “hawks” (SPs who score too harshly) or “doves” (SPs who score too leniently) in the group and bring them in line with the standard. Finally, any remaining questions are asked and answered, a quick review of the schedule is done, and the SPs are reminded to read the case scenario, memorize it, and practice it prior to the exercise.

**NOTE: For the GRIEV\_ING death notification simulation, the scenarios present cases in which the resident must communicate with the survivor(s) of a deceased patient. Therefore, the actors will be portraying survivors rather than patients and thus may be thought of as “standardized survivors.”**



**ATTACHMENT F**

**Case A**

**UPDATE FOR RESIDENT**

**Patient's Name:** Bart Irons

**Medical Profile:** Healthy 12-year-old male, victim of bike/car accident this morning. A car struck him from behind, and he was not wearing a helmet.

**Survivor Present:** Grandparent Mr. or Mrs. Irons (paternal grandparent)

**Background:** Grandparent has been staying with Bart and his younger sister for two days while the father is away on business. It is a teacher workday, and Bart was riding bikes with a friend. The friend was not injured but did witness the accident. The grandparent arrived at the hospital a few minutes after the ambulance arrived and has been in the private waiting area for about 30 minutes. The grandparent has received an initial update and is aware that Bart has experienced severe trauma to his head and that his prognosis is poor.

**Patient's Present Condition:**

Bart was brought to the ED as a Code Red trauma "Ped struck by Car." EMS estimates that he was struck by a car traveling at about 45-55 mph and thrown from his bike. He landed approximately 30 feet from the point of initial impact. Field assessment per EMS revealed multiple extremity, facial and head injuries as well as extensive skin loss secondary to being thrown from his bike and then skidding across the pavement. The patient was unconscious and responded only to deep painful stimuli.

Vital signs in the field:

Pulse	170
Blood Pressure	90/50
Respiratory Rate	36

Patient was placed in full spine immobilization, two large bore IV's were started, and he was infused with 2 liters of normal saline before arrival in the ED. Transport time was estimated to be 5 minutes. The patient vomited immediately after arrival in the ED, and one of the IV's was dislodged when he was rolled to prevent aspiration. Vital signs were noted to be:

Pulse	185
Blood Pressure	50/p,
Respiratory Rate	40
Weight	estimated to be 50 kg

ABC assessment revealed the following injuries: Cool, pale, male patient on a long spine board with c-collar in place. Extensive head and face injuries with a blood-soaked gauze dressing surrounding the posterior and superior scalp. The breath sounds were audible bilaterally, but left breath sounds were distant. The trachea was midline, and the jugular veins were flat. The skin of the left chest wall was ecchymotic, and the left chest, flank, abdomen and pelvis were denuded

of skin and embedded with gravel. The abdomen was distended and tense. The left arm had open fractures of both the humerus and the radius and ulna. The left hand was cold and mottled. The pelvis opened to direct downward pressure. The left femur was noted to have an obvious fracture at mid-shaft, and there was extensive swelling of the left thigh. There were diminished distal pulses on the right, but the left dorsalis pedis pulse was not palpable. Neurologically the patient responded only to painful stimuli with decerebrate posture, pupils were dilated and un-reactive bilaterally, toes were upward going bilaterally.

Rapid sequence intubation was performed with etomidate and succinylcholine. At the time of airway placement, the patient's entire midface was noted to be mobile, and there was a large amount of blood from both ears and the posterior aspect of the scalp. An extensive laceration was noted to extend from the left ear to the post scalp, with bone visible at the base of the laceration. Tube placement was confirmed with end-tidal CO<sub>2</sub> and bilateral breath sounds; however, immediately after beginning to bag the patient, extensive subcutaneous air began to develop along the left chest wall. A right groin line was secured and the patient immediately transfused with 2 units of packed red blood cells followed by an ongoing aggressive fluid and blood product resuscitation. A chest tube was placed in the left chest with the release of a large whoosh of air, and 1800 cc of blood immediately collected in the Pneumo-vac. Immediately following chest tube placement, the patient's BP responded with an increase in the systolic pressure to 110 mm Hg but dropped again into the 50's mm Hg within minutes. At that time the patient's heart rate also began to fall.

Fifteen minutes into the resuscitation, the patient's vital signs were pulse 30, BP not palpable, respirations ventilated with 100% O<sub>2</sub>, rate 18, end-tidal CO<sub>2</sub> = 36, pulse ox 100%. CPR was initiated, and the patient was administered epi via the femoral line. The heart rate did not respond, and soon after CPR was initiated, spontaneous heart activity stopped. Fluid and blood transfusion continued via the Level One Rapid Infuser at the rate of 1 liter per 1.5 minutes. The Pneumo-vac continued to have high output, and the bed and floor under the patient's head were noted to have extensive pooling of blood. The patient did not respond to resuscitation measures. Due to the large amount of blood pooling under the head area, the scalp laceration was examined for a possible hemostatic closure. At the time of field dressing removal, gray matter was noted to extrude from the posterior aspect of the skull. Multiple bony fragments and scalp sections were found in the dressing. Due to failure to respond to full trauma code measures for more than 35 minutes and the overwhelming nature of the head injury, the resuscitation was called 50 minutes after arrival in the ED. The patient had received 10 rounds of epi, 18 liters of LR in the ED + 2 in the field for a total of 20 liters of fluid. In addition, the patient was administered 6 units of packed red blood cells and 2 6-packs of platelets. He was declared dead at 11.23 am.

**You have 15 minutes to inform the grandparent of Bart's death and answer any questions he/she may have.**

# Case A

## TRAINING MATERIALS FOR STANDARDIZED SURVIVOR

**Case A:** Mr. or Mrs. Irons (Standardized Survivor and paternal grandparent of patient)

### Survivor Profile

- A. Age: 60-70
- B. Gender: male or female
- C. Race: Caucasian
- D. Affect (mannerisms, behavior): Anxious and stunned; beginning to express guilt
- E. Social History/Lifestyle: Retired to Chapel Hill to be near son's family
- F. Occupation: retired
- G. Marital Status: Widowed
- H. General Appearance: Neat in appearance, but face is pale and eyes are red

### Scenario

Bart Irons, a 12-year-old male, was riding his bike along Estes Drive Extension this morning when he was struck by a car from the rear. All of the details of the accident are not yet clear, but it appears that Bart was riding away from the mall and towards 15-501/Fordham Boulevard when he rode through an intersection and was hit. His friend Michael was riding the same route but was further behind and was not involved in the accident. Michael, who was spending the teacher workday with Bart, informed the medics of Bart's last name and home phone number.

You have been staying with Bart and his younger sister this week. You were notified by the authorities and are present in the emergency room. Bart's father is out of town (his mother lives in Canada and the father has custody). You contacted Bart's father's office, and he is being reached at a professional meeting in Chicago. You have also contacted Bart's aunt who lives in Wilmington, and she is on her way to Chapel Hill. It is expected that the father will call the hospital as soon as he gets the message that there has been an accident.

You are terribly shaken, as the initial report on Bart's condition was very discouraging. Bart has sustained massive head injuries and is not conscious. There is swelling around the brain, and the pressure has to be relieved. You have given permission for any necessary procedures. This encounter (with the resident who delivers the notice of Bart's death) occurs approximately 20 minutes after you arrived at the Emergency Department Waiting Area. You are alone and anxious to see Bart and communicate with Bart's father. Bart is the eldest grandchild, and you are very close to Bart; you came to Chapel Hill to retire near your son and his family. Bart was active in Sunday school, played soccer, and was a good student. You are in prayer when the resident enters the room. You stand to greet the resident and ask: "How is Bart?" You vacillate between disbelief and grief, asking several questions in sequence and not always waiting for an answer from the resident.

You are in shock and terribly guilt-stricken, as Bart was not supposed to ride his bike on the primary roads. It is not clear why Bart left the neighborhood street, and you have not had a

chance to speak with Michael, the boy who was riding with Bart. The policeman who called the house said that Michael had stopped at the Texaco station to get some air in his front tire, so he was a good distance behind Bart. Bart rode into the intersection and turned right without yielding to oncoming traffic and, apparently, was hit from the rear by a car approaching from his left. Bart was not wearing his helmet. The police took Michael home and you have not really had a chance to get additional details of the accident.

You will volunteer the following information when informed that Bart is dead:

“Bart was supposed to be wearing a helmet—he is not allowed to ride without it!”

“Bart is so full of life, I can’t believe this is happening!”

“Bart is the center of his dad’s universe....”

You are active in a local church (survivor picks one with which he/she is familiar) and ask that the hospital chaplain contact your minister.

### **Instructions for Survivor**

**A. How the survivor responds to the physician’s initial inquiry.**

When the resident enters the room, ask, “How is Bart?”

**B. The survivor’s *demeanor* at the beginning and throughout the encounter (affect, non-verbal behavior).**

You are stunned, display a sense of guilt, and are overwhelmed by the unfolding events. There is no anger, just disbelief at this point. At the beginning, you will not yet fully understand that the grandson is dead. Drop your head in your hands in disbelief and grief.

**C. The survivor’s *concerns regarding his/her understanding of the situation.***

You are stunned and have difficulty accepting that Bart is dead. Ask several questions accordingly. Use present tense when speaking about the deceased.

**D. How the survivor will *respond to different interviewing styles.***

Your response will be the same regardless of the resident’s communication style.

**E. Questions the survivor will *consistently ask during the encounter.***

“Did he suffer great pain?”

“Can I see him?”

“Would the helmet have saved him?”

**\*\* In response to resident's inquiry about further questions:**

“What can I tell my son—his father?” “Will someone talk to him when he calls?”

“Someone will have to contact my ex-daughter-in-law.”

**F. The *challenges* the survivor will present to the physician.**

You are struggling with the issue of guilt because the grandson was riding in a forbidden area without a helmet. In addition, you may not be able to answer all the physician’s questions.

### **Guide to the items that the resident should address:**

#### **Gathered the family**

The resident must elicit that the parents are out of town and the grandparent has guardian rights and responsibilities.

**Resources**

Determines that the survivor wants his/her local minister contacted.

**Identify**

The resident must introduce himself/herself and identify the patient, Bart Irons, and clarify the events up to this point.

**Educate**

Educate the grandparent as to what has transpired in the Emergency Department and be definite about communicating the patient's death.

**Verify**

Verify that Bart is dead—must use the words “dead” or “died.” Give the grandparent time to absorb this information and to express emotion.

**Inquire**

Ask if there are any questions; answer all questions

**Nuts and Bolts**

Inquire about organ donation, funeral services, personal belongings; offer an opportunity to view the body.

**Give**

Give the survivor a professional card and offer to be available for further questions.

*The Standardized Survivor will complete both the GRIEV\_ING Competence Instrument (based on the items above) and a Relationship and Communication Form following each encounter.*

# Case B

## UPDATE FOR RESIDENT

**Patient's Name:** Regina Cook

**Medical Profile:** The victim, a widow in her mid-70s, was found by her daughter/son this afternoon. Mrs. Cook was found at home after being beaten and robbed. Her daughter/son is very concerned but is not aware of the severity of Mrs. Cook's injuries. Mrs. Cook sustained a depressed skull fracture, and a liver laceration. She had extensive internal bleeding and had been on the floor of her home for an undetermined period of time (likely more than 8 hours). She was hypothermic at 29 degrees when assessed by EMS.

**Survivor Present:** Sherry or Jimmy Cook, daughter or son of Mrs. Cook.

**Background:** Mrs. Cook last saw her daughter or son several weeks ago, and they had planned to meet today for a routine medical check up. When Sherry/Jimmy arrived around 2:45pm, she/he used her/his key to enter the house and upon entry, immediately noticed that things were in disarray. Several items were turned over, and belongings that were once in drawers were now all over the floor. She/he found the mother on the floor of the den, beaten and unconscious. After trying to wake her and getting no response, she/he immediately called 911. When the emergency medical technicians arrived, they found Mrs. Cook to be cold with a temp of 29 degrees. Her left pupil was dilated and fixed. Her abdomen was firm and rigid.

Upon arriving at the hospital, the daughter/son was informed that Mrs. Cook was in critical condition, but no other information was given. She/he is in the process of contacting the other siblings when you enter the room.

### **Patient's Present Condition:**

Mrs. Cook was transported to your ED by local EMS in full spine immobilization with a 22 gauge IV in her right hand. She had received 500 cc of NS in transport. Her initial ABCs revealed rapid respiration at a rate of 24, shallow, with no gag reflex; her blood pressure was 58/p, HR 98 with a temp of 29 degrees.

Secondary survey revealed facial lacerations and a fixed and dilated left pupil. You noted extensive ecchymosis of her left side, which appeared to be the result of a combination of direct trauma from the assault and a prolonged period of immobility with her left side down. Her abdomen was rigid to the touch. While IV lines were being established, the patient's heart rate dropped into the 40s, and she began decorticate posturing. You began the process of induction for intubation when the patient had a v-fib arrest. CPR was initiated and a central line placed with warm fluid infusion. Despite multiple shocks, rounds of epi, aggressive fluid-resuscitation, and rewarming, the patient never returned to spontaneous circulation. She did not survive to CT scan to define the extent of her injuries.

You have 15 minutes to inform the son/daughter of the mother's death and answer any questions he/she may have.

# Case B

## TRAINING MATERIALS FOR STANDARDIZED SURVIVOR

**Case B:** Sherry or Jimmy Cook (Standardized Survivor and daughter/son of patient)

### Survivor Profile

- A. Age: 45-55
- B. Gender: male or female
- C. Race: (same as patient)
- D. Affect (mannerisms, behavior): Survivor daughter/son is in shock and disbelief. She/he went to pick up her/his elderly mother who lives alone for a doctor's appointment. Upon entry into the house, she/he found several things turned upside down and her/his mother beaten and unconscious. She/he immediately called 911 and rode in the ambulance to the hospital. She/he has two other sisters who live in another state.
- E. Social History/Lifestyle: The survivor is the patient's oldest child and has been somewhat resentful in the past that she/he is the only child living in town and taking care of her/his widowed mother. The patient lived about 20 minutes from the survivor. The survivor had tried several times to talk her/his mother into coming to live with her/his family, but the patient repeatedly refused, stating that she didn't want to be a burden. The two sisters who live out of town were paying for someone to stay overnight with their mother, but they couldn't afford to pay someone to help during the day as well.
- F. Occupation: Survivor works as a business administrative assistant. Patient did not work outside the home.
- G. Marital Status: Patient is widowed. Survivor is married.
- H. General Appearance: Survivor is dressed in business casual clothes, since she/he had to leave work early to take her/his mother to the doctor's appointment.

### Scenario

Regina Cook, your mother and a widow in her mid-70s, lives alone about 20 minutes from the city. She lives in the same house that she raised you and your two sisters in, which is located on 10 acres of land. She had a doctor's appointment this afternoon, and you planned to pick her up at 3pm to accompany her to the visit. You arrived around 2:45pm and used your key to enter the house (since your mother has had difficulty in the past hearing knocks at the door). Upon entry, you immediately noticed that things were in disarray. Several items were turned over and belongings that were once in drawers were now all over the floor. You found your mother on the floor of the den, beaten and unconscious. After trying to wake her and getting no response, you immediately called 911. When the emergency medical technicians arrived, their comments scared you, and you fear that your mother is in real danger.

When the resident enters the room, you have just left a message for your sisters. You have also just decided that your mother must have a full-time person to stay both days and nights to prevent this from ever happening again.

You are in disbelief when informed that your mother has died. Your mother has always been a very strong woman, the pillar of the family, and you are finding it hard to believe that she did not



survive this experience. You were frightened, but you were sure that the hospital could save her. After all, she was otherwise in very good health.

You also are having a lot of guilt that you were not able to provide her with 24-hour care, as well as feeling guilty about having resented in the past being the only child in town to help take care of her. You wonder what you will tell your sisters.

### **Instructions for Survivor**

- A. **How the survivor responds to the physician's initial inquiry.**  
You are somewhat shaken by the events of the afternoon, but you are expecting your mother to pull through. You have just left a message for your sisters when the resident enters. *Your opening statement to the resident is: "Is mom OK?"*
- B. **The survivor's demeanor at the beginning and throughout the encounter (affect, non-verbal behavior).**  
You are initially calm but become very upset when told your mother has died. You rise and ask your opening question when the resident comes in, but sit immediately upon hearing the bad news.
- C. **The survivor's concerns regarding his/her understanding of the situation.**  
You are concerned that you will not be able to convey the events of the day to your sisters.
- D. **How the survivor will respond to different interviewing styles.**  
Your style of conversation is the same regardless of the resident's actions or comments.
- E. **Questions the survivor will consistently ask during the encounter.**  
"Is mom OK?" Ask when resident enters the room.  
"How could I let this happen?"  
"What am I going to tell my sisters?"
- F. **The challenges the survivor will present to the physician NA**

### **Guide to the items that the resident should address:**

#### **Gathered the family**

The resident must elicit that the survivor is only one of the patient's three children and that the other two siblings are not available—the essential questions must be asked of the survivor present.

#### **Resources**

Determines that the patient has two sisters and a spouse and thinks they should be contacted immediately. The survivor will ask if a chaplain can be available right now.

#### **Identify**

The resident must introduce himself/herself and identify the patient, Regina Cook, and clarify the medical events up to this point.

**Educate**

Educate the survivor as to what has transpired in the ER, and be definite about communicating the patient's death.

**Verify**

Verify that Regina is dead—must use the words “dead” or “died.”

**Inquire**

Ask if there are any questions; answer all questions

**Nuts and Bolts**

Inquire about organ donation, funeral services, personal belongings; offer an opportunity to view the body.

**Give**

Give the survivor a professional card and offer to be available for further questions. Link the survivor to local resources, such as supportive services for families after a homicide.

*The Standardized Survivor will complete both the GRIEV\_ING Competence Instrument (based on the items above) and a Relationship and Communication Form following each encounter.*

# Case C

## UPDATE FOR RESIDENT

**Patients' Names:** Chuck Fromme and Eric Kraftstein

**Medical Profiles:** Two healthy seventeen-year-old high-school seniors were in an accident tonight. The SUV, driven by Chuck Fromme, ran off the road on a curve, overturned at least twice, and landed on the passenger side where Eric Kraftstein was seated. Chuck sustained multiple facial lacerations, two broken legs, and a collapsed lung. Eric sustained severe head trauma and a broken right leg.

**Survivor Present:** Mr. or Mrs. Fromme, parent of Chuck and host parent of Eric.

**Background:** Mr./Mrs. Fromme saw Chuck and Eric off to the holiday dance this evening. Eric is a foreign exchange student attending the local high school, and the Frommes are his host family. Mr./Mrs. Fromme was contacted by phone tonight and told that his/her son had been taken to the Emergency Department as a result of an automobile accident. The accident occurred about 10:30 pm, and it is now midnight. Upon arriving at the hospital, Mr./Mrs. Fromme was informed that Chuck was stable but that Eric's condition was critical. As custodial parent, Mr./Mrs. Fromme was asked to give permission for surgery to relieve pressure on Eric's brain. There has been no update in the past 30 minutes.

### **Patients' Present Condition:**

**Chuck Fromme:** Chuck was extricated from the driver's seat of the vehicle with obvious fractures of the L femur and the right ankle. The right ankle injury is open. He had labored respirations and an obvious chest injury. VS in the field were BP 95/50, p 140, rr 36. He was transported with full spine immobilization, and immediately upon arrival in the ED, an L chest tube was placed with improvement in the VS to BP 102/85, p 120, rr 28. His femur was placed in a Hare traction splint, and he was prepped for the OR by Ortho to irrigate and close the open ankle injury. His blood alcohol content was 0.10. He is considered in stable condition at this time.

**Eric Kraftstein:** Eric was extricated from the passenger's seat of the vehicle with signs of closed head injury. He was decorticate posturing and did not respond to verbal or painful stimuli. His teeth were clinched, and he had gurgling respirations. Blood and CSF were streaming from his nose. VS were BP190/145, p70, rr 38. He was transported by EMS to the ED in full spinal immobilization, and bag-valve-mask ventilatory assist was performed with 100% O<sub>2</sub>. Upon arrival in the ED, he was immediately intubated with RSI. His neuro exam was unchanged, with no response to verbal or painful stimuli and intermittent decorticate posturing. His vital signs post-intubation were BP 220/165, p 70, and rr vent setting=16; he was over-breathing the vent at rate of 32. Neurosurgery elected to perform a ventriculostomy, and during the procedure Eric became progressively bradycardic. He arrested, and the resuscitation attempt with CPR, drugs,

and fluid failed to return him to a spontaneous cardiac rhythm. He was pronounced dead one hour after entering the trauma room.

You have 15 minutes to inform the host parent of Eric's death and answer any questions he/she may have. (Chuck, the son, is being prepared for surgery on his legs and is responding well.)

# Case C

## TRAINING MATERIALS FOR STANDARDIZED SURVIVOR

**Case C:** Mr. or Mrs. Fromme (Standardized Survivor and parent of one patient and host parent of the other)

### Survivor Profile

- A. Age: late 40's/early 50's
- B. Gender: male or female
- C. Race: Caucasian
- D. Affect (mannerisms, behavior) Nervous, concerned and anxious—twisting hands frequently and showing brief spurts of emotion (appears to be in tears); paces
- E. Social History/Lifestyle: middle class, involved single parent
- F. Occupation: Use your own history.
- G. Sexual History: not in a relationship at this time
- H. Marital Status: widowed
- I. General Appearance: Neat and professional in appearance, but clearly anxious and distraught.

### Scenario

You are a single parent due to the death of your spouse (lung cancer) several years ago. You were contacted by phone tonight and told that your seventeen-year-old son had been taken to the Emergency Department as a result of an automobile accident. The accident happened about 10:30 pm, and it is now midnight. Your son, Charles (Chuck to his friends and family), has two broken legs, extensive facial lacerations, and a collapsed lung. He is being sutured and is expected to undergo surgery on his legs later this morning.

Another major concern for you is that there was a second passenger, a male exchange student named Eric, who is living with you this semester. The boys had driven away from a dance at Chapel Hill High tonight when the accident occurred. Based on the observation of an oncoming driver, the EMS folks informed the police that the SUV was weaving back and forth between the center line and the edge of the road when it swerved at a curve. The SUV rolled and landed on the passenger's side. The exchange student's condition is critical, and the physicians have asked you, as custodial host parent, to give permission for surgery to relieve pressure on Eric's brain and to help confirm the identity of the passenger.

You are devastated over the accident and very concerned about both your son and the exchange student, Eric. You have not been able to question Chuck about the accident but you were allowed to see him very briefly. He was covered in blood still and looked awful. You have not been allowed to see Eric. About 30 minutes ago, you were informed that the prognosis for Chuck is improving but that the prognosis for Eric is poor.

This interaction occurs when the resident comes to inform you that your son, Chuck, is stabilizing and is about to undergo surgery on both legs, but that the exchange student, Eric, has died.

### **Instructions for Survivor**

- A. **How the survivor responds to the physician's initial inquiry.**  
When the resident enters the room, ask, “How are they?” “Is Chuck stable? Has Eric shown any improvement?” Express relief that Chuck is stable and appears not to have major internal injuries, but show much concern about Eric.
- B. **The survivor’s *demeanor* at the beginning and throughout the encounter (affect, non-verbal behavior).** You are anxious, wringing your hands and pacing while speaking with the physician. Vacillate between gratefulness that Chuck is going to recover and being distraught over Eric’s perilous condition. Talk about being responsible for another family’s child: how can you possibly explain the accident that occurred when your son was driving?
- C. **The survivor’s *concerns regarding his/her understanding of the situation.***  
Ask how Chuck can be recovering while Eric experienced much more severe injuries. You want to do everything Eric’s parents would do at this time. Ask what can be done for Eric.
- D. **How the survivor will *respond to different interviewing styles.*** You are looking for some reassurance regarding both young men’s conditions. If the physician does not address the extreme difficulty of the situation and only tries to “take care of business,” exhibit tears of frustration and controlled anger.
- E. **Questions the survivor will *consistently ask during the encounter.***  
“Can I see Chuck before he goes into surgery?”  
“Does Chuck know about Eric's condition?”  
“What can we do for Eric?”  
“Can someone speak with his parents when they call?”
- F. **The *challenges* the survivor will present to the physician.**  
You are very emotional.

### **Guide to the items that the resident should address:**

#### **Gathered the family**

The resident must elicit that the survivor is the host parent and that no immediate family is available—the essential questions must be asked of the survivor present.

#### **Resources**

Determine that the survivor has a card with the name of the exchange program contact, who should be called in order to notify Eric’s parents.

**Identify**

The resident must introduce himself/herself, identify the patients, and clarify the medical events up to this point.

**Educate**

Educate the survivor as to what has transpired in the ER and be definite about communicating the patient's death.

**Verify**

Verify that Eric is dead—must use the words “dead” or “died.”

**Inquire**

Ask if there are any questions; answer all questions

**Nuts and Bolts**

Inquire about organ donation, funeral services, personal belongings; offer an opportunity to view the body.

**Give**

Give the survivor a professional card and offer to be available for further questions.

*The Standardized Survivor will complete both the GRIEV\_ING Competence Instrument (based on the items above) and a Relationship and Communication Form following each encounter.*

# ATTACHMENT G

## ADDITIONAL CASES FOR DEVELOPMENT

(Cases provided by John M. Evans, National Victim Services Training Manager, MADD)

1. Danny Hicks, 27, arrived at the ED via ambulance. He was riding his road bike and was struck by a vehicle whose driver allegedly ran a red light, hitting him at 50 miles per hour. He sustained massive internal injuries and died on the operating table. His fiancée has just arrived at the hospital.
2. Tonya Jones, 6, was brought to the ED via ambulance. She slipped, hit her head, and fell into the family pool while retrieving a new birthday toy after dinner. A short time later, her mother noticed she wasn't in the house and stepped out back, finding her face down in the pool. She was pronounced dead shortly after arrival. Mom and Dad are in the waiting room.
3. Stefanie Villanueva, 13, was transported to the ED after a vicious dog attack. Parts of her face and throat were torn off. She had coded in the ambulance and was pronounced dead after a 27-minute attempt to establish a heartbeat proved unsuccessful. Her grandmother is anxiously awaiting promising news.
4. Delores Pickney, 33, came into the ED complaining of painful abdominal cramping and bleeding. Delores is 6½ months pregnant after a previous miscarriage 3 years earlier. Examination reveals no sign of a heartbeat. The fetus is taken. Delores is in recovery, and her husband is in a waiting room. They planned to name the child Erika Hope Pickney.
5. Rafael Archuleta, 44, arrived in the ED following a traumatic motorcycle crash. Another vehicle swerved into his lane, forcing him into the cement highway divider along the Interstate. He and his motorcycle were struck by four different vehicles before the chain of events concluded. Rafael was declared dead shortly after his arrival. His wife, Eva, has now arrived at the ED and is demanding to know what is happening.
6. Casey Linden, 23, arrived at 5:23 AM by ambulance following a suspected methamphetamine overdose. He was found on his bed face down, not breathing, by a friend who had passed out earlier on the living room couch. All efforts to revive Casey in the ED failed, and he was pronounced dead. His friend is in the waiting room.
7. Marion Wilson, 53, was brought to the ED by LifeFlight from the state park. She and her husband were in a lake testing some used scuba gear they bought at a pawn shop.



Her husband reported she was beside him and everything was fine. A moment later he turned and she wasn't there. He found her sinking motionless, with a small stream of bubbles coming from her equipment. He pulled her to the surface and yelled for help. CPR was administered on shore until paramedics arrived. The paramedics established a shallow heartbeat and transported by helicopter. She died during the flight. Wesley Wilson, her husband of 31 years, is in the waiting room.

8. Officer Raymond Blackwell, 41, was rushed to the ED with a gunshot wound to his chest. He was shot by his ex-wife's boyfriend while attempting to withdraw money from an ATM machine. The bullet penetrated his heart, and he bled to death. His partner, Officer Scott Jones, stands anxiously in the waiting area.

## Attachment H

# TEMPLATE FOR DEVELOPING ADDITIONAL STANDARDIZED PATIENT SCENARIOS

SCENARIO

CASE: NAME

(The expanded description of the *clinical, psychosocial, and presentation* information)

**CASE NAME (#)**

**Author:**

**I. Patient Profile**

- A. Age:**
- B. Gender:**
- C. Race:**
- D. Affect (Mannerisms, Behavior):**
- E. Social History/Lifestyle:**
- F. Occupation:**
- G. Sexual History:**
- H. Marital Status:**
- 1. Habits:**
- J. General Appearance:**

## **II. History of Present Illness**

**Location:**

**Quality:**

**Quantity/Severity:**

**Onset:**

**Duration:**

**Frequency:**

**Aggravating/Alleviating Factors:**

## **III. Past Medical History**

**General State of Health:**

**Prior Illnesses or Injury:**

**Cardiovascular:**

**Respiratory:**

**Past Hospitalizations:**

**Gastrointestinal:**

**Allergies/Immunizations:**

**Genitourinary:**

**Current Medications:**

**Gyn:**

**HEENT/Neurologic:**

**Hematologic:**

**Psychiatric:**

**Breasts:**

**Dental:**

#### IV. Physical Exam Results

##### General Appearance:

- **Vital Signs:** BP (sitting):            BP (standing):            RR:  
(BP, blood pressure; RR, respiratory rate)
- **General:**
- **Gastrointestinal:**
- **Skin:**
- **Genitourinary:**
- **HEENT:**
- **Gyn/Breast:**
- **Musculoskeletal:**
- **Respiratory:**
- **Peripheral Vascular:**
- **Cardiovascular:**
- **Neurologic:**
- **Mental Status Exam:**
- **Hematologic:**
- **Dental:**

#### IV. Family History

	Age	Health	Cause of Death
Parents:	Father		
	Mother		
Siblings:			
Children:			

## V. Scenario Development

- A. **Describe** *why the patient is seeing the physician, including* the specific opening statement. **"I want to know if I can drive my car."**
- B. **Describe the patient's demeanor at the beginning and throughout the encounter.**
- C. **Describe the patient's concerns regarding his/her understanding of the presenting problem.**
- D. **Describe how the patient will respond to different interviewing styles.**
- E. **Triggers: What questions will the patient consistently ask during the encounter?**
- F. **Describe the challenges the patient will present to the physician** (e.g., as the physician shows interest in the patient, the initially hostile patient will decrease his/her hostility).

## VI. Supplemental Materials

Anything not provided in the standard room set-up.

## ATTACHMENT I

### GRIEVING COMPETENCE INSTRUMENT

#### Long Form

**Directions:** Please indicate whether the physician completed the stated actions, with **Y = completed (Yes)** or **N = did not complete (No)**

#### **The Physician...**

##### G—Gather

1. Ensured that all important survivors were present prior to delivery of the death notification.

##### R—Resources

2. Inquired about supportive resources.  
 3. Facilitated access to supportive resources.

##### I—Identify

4. Clearly stated the name of the patient.  
 5. Clearly introduced herself/himself.  
 6. Clearly stated his/her role in the care of the patient.

##### **Check for Understanding**

7. Determined the level of knowledge the survivors possessed prior to their arrival in the waiting room.  
 8. Provided an appropriate opening statement (i.e., avoided bluntly stating death of patient).  
 9. Used preparatory phrases to forecast the news of death.

##### E—Educate

10. Clearly indicated the chronology of events leading up to the death of the patient.  
 11. Clearly indicated the cause of death in an understandable manner.  
 12. Used language appropriate for the survivor's culture and educational level.  
 13. Provided a summary of important information to ensure understanding.

##### V—Verify

14. Used the phrase "dead" or "died."  
 15. Avoided using euphemisms.  
 16. Avoided medical terminology/jargon or clearly explained such terms when used.

##### **Space**

17. Was attentive and not rushed in his/her interaction with survivor.  
 18. Paused to allow the family to assimilate the information before discussing details.

##### I—Inquire

19. Allowed the survivor to react to the information and ask questions or express concerns.  
 20. Encouraged the survivor to summarize important information to check for understanding.

\_\_ 21. Immediately but appropriately corrected any misconceptions of the survivor.

**N—“ Nuts and bolts”**

Explained and addressed the following details of the patient's post-mortem care adequately.

\_\_ 22a. Organ donation

\_\_ 22b. Need for an autopsy

\_\_ 22c. Funeral arrangements

\_\_ 22d. Personal effects

**G—Give**

\_\_ 25. Established personal availability to answer questions for the survivor at a later date.

\_\_ 26. Provided the survivor appropriate information to contact the physician at a later time.

\_\_ 27. Provided the survivor appropriate information to contact resuscitation or post-mortem care providers.



## GRIEV\_ING COMPETENCE INSTRUMENT

### **Short Form**

**Directions:** Please indicate whether the physician completed the stated actions, with **Y = completed (Yes)** or **N = did not complete (No)**

#### **The Physician...**

##### **G—Gather**

\_\_1. Ensured that all important survivors were present prior to delivery of the death notification.

##### **R—Resources**

\_\_2. Facilitated access to supportive resources.

##### **I—Identify**

\_\_3. Clearly stated the name of the patient.

\_\_4. Clearly stated his/her role in the care of the patient.

##### **Check for Understanding**

\_\_5. Determined the level of knowledge the survivors possessed prior to their arrival in the waiting room.

##### **E—Educate**

\_\_6. Clearly indicated the cause of death in an understandable manner.

##### **V—Verify**

\_\_7. Avoided using euphemisms.

##### **Space**

\_\_8. Paused to allow the family to assimilate the information before discussing details.

##### **I—Inquire**

\_\_9. Encouraged the survivor to summarize important information to check for understanding.

##### **N—“Nuts and bolts”**

\_\_10. Explained and addressed post-mortem details, including organ donation.

##### **G—Give**

\_\_11. Established personal availability and provided contact information to answer questions for the survivor at a later time.

## ATTACHMENT J

### RELATIONSHIP AND COMMUNICATION INSTRUMENT

#### To be completed by Standardized Patient (Standardized Survivor)

*SCALE: 1=poor 2=fair 3=good 4= very good 5= excellent*

HOW WAS THE RESIDENT YOU JUST SAW AT...

- 1 2 3 4 5 A. greeting you warmly; being friendly, never crabby or rude
- 1 2 3 4 5 B. treating you like you are on the same level; never “talking down” to you or treating you like a child
- 1 2 3 4 5 C. letting you tell your story; listening carefully; asking thoughtful questions; not interrupting while you are talking
- 1 2 3 4 5 D. showing interest in you as a person; not acting bored or ignoring what you have to say
- 1 2 3 4 5 E. encouraging you to ask questions; answering them clearly; never avoiding your questions or lecturing you
- 1 2 3 4 5 F. using easily understood words when explaining the situation; explaining any technical medical terms in plain language

*Scale: 1=not at all 2= very little 3=some 4=quite a bit 5= a lot*

WITH THIS RESIDENT, TO WHAT DEGREE DID YOU FEEL...

- 1 2 3 4 5 G. Respected
- 1 2 3 4 5 H. Comfortable/At ease
- 1 2 3 4 5 I. Understood

## Notes on the Relationship and Communication Items

The nine-item checklist represents the factors that influence the quality of the doctor-patient relationship. Each patient has a slightly different set of expectations when visiting a physician and slightly different standards for the physician's approach.

All of the following are related and important. Use the entire scale when rating on each statement, and remember that you must be CONSISTENT in your ratings. In other words, maintain the same standards for physician performance for each encounter.

### HOW WAS THE RESIDENT AT...

- Greeting you warmly; being friendly, never crabby or rude

This includes how the physician greeted you initially, the tone of his/her conversation with you for the entire encounter, and whether he/she was ever rude, indignant, or indifferent.

- Treating you like you are on the same level; never "talking down" to you or treating you like a child

This relates to whether the resident treated you as an equal or implied that you were not capable of being an equal partner.

- Letting you tell your story; listening carefully; asking thoughtful questions; not interrupting while you are talking

This relates to being an active listener. Did the physician summarize what you said to him/her?

- Showing interest in you as a person; not acting bored or ignoring what you have to say

Did the physician respond to your statements or questions? Did s/he seem interested in your specific needs or challenges?

- Encouraging you to ask questions; answering them clearly; never avoiding your questions or lecturing you

Did the physician take your questions seriously and answer them fully, not just with yes/no responses?

- Using easily understood words when explaining the situation; explaining any technical medical terms in plain language

Did the physicians avoid using medical jargon and explain procedures using layperson's terms?

### WITH THIS RESIDENT, TO WHAT DEGREE DID YOU FEEL...

- Respected

This means that the physician behaved courteously without regard for your age, gender, race, or socioeconomic status.

- Comfortable/at ease

This means that the physician's approach made you feel equal and willing to discuss any topic with the physician.

- Understood

This means that the physician acknowledged your feelings and opinions, and you felt that he/she clearly stated and appreciated your perspective.