

Part C: Managing Emotions after Difficult Patient Care Experiences

Cases: Senior Debriefing Role Playing

Case 1: 4 year old girl with idiopathic pulmonary hypertension

It is the first week in July. A 4yo girl with idiopathic pulmonary hypertension is admitted to the cardiology team for observation following her yearly routine cardiac catheterization. The procedure is successfully performed in the morning. The interventional cardiologist and family will decide later on in the day whether they would like to be discharged in the evening or whether they would like to stay the night. At 8PM patient develops a pulmonary hypertensive crisis. A code is called, but resuscitation efforts are unsuccessful and the child dies. The next morning rounds proceed on as usual and no one mentions the patient.

Senior resident: *You are the senior resident on the cardiology service. Your interns seem to both be pretty dazed on rounds and one seems close to tears, but they're going through the routine. Neither the cardiology fellow nor the attending mentions the child's death, and now rounds are over and your pager is going off.*

Intern 1: *You admitted the patient and prior to running off to continuity clinic, signed her out to your co-intern as very stable and likely to be discharged home in the evening. Being a "good intern" you had all of her discharge paperwork and prescriptions completed prior to leaving the hospital. All your daytime or nighttime colleague has to do is click "sign" on the discharge summary.*

When you arrive to pre-round the following day you are not surprised by the patient's room being empty and assume she had gone home the night before. Everything seems as usual on the floor. You receive sign-out immediately before the early morning combined CT surgery/cardiology rounds, and are shocked to hear about the patient's death.

You feel dazed...and guilty. You remember you rushed through the admission as it was a "routine" observation case with a very straightforward history, and you were getting two complex congenital heart disease post-op patients from the CICU the same morning. You realize you never asked about code status or even tried to begin to understand what it meant to the family to be living with the type of illness where a child could be perfectly well one minute and die the next. Now you'll never get the chance. You're afraid you spent more time on paperwork (still trying to figure out the electronic medical record!) than you did with the family. You feel like crying but rounds are going on as usual and you're getting called with new admissions.

Intern 2: *You are the other intern on the cardiology service. Your co-intern signs out her service to you prior to rushing off to clinic and you in turn sign it out to the night-time intern as: "4 y/o, idiopathic pulmonary hypertension, routine post-cath observation. If you get called that parents want to go home, sign the discharge summary. Everything is ready." You're not aware she has died until your co-intern mentions something after rounds. You're surprised but don't know what else to feel. She was technically "your" patient for about 5 hours but you never actually laid eyes on her and never talked to the family. Now you wonder if you were supposed to. It's your first patient death, but doesn't feel real. Rounds are going on as usual and you wonder if that's the way all deaths are treated.*

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Intern 3: You are the nighttime intern on the endocrine service, providing cross-coverage for the cardiology service at night. The sign-out you got on the cardiology patients is a bit overwhelming as you are pretty vague on what things like “hypoplastic left heart,” “Glenn,” or “Fontan,” actually mean, and which of “your” nighttime patients are supposed to have oxygen saturations in the 70s. You’ve created a mental “to read” list and added “idiopathic pulmonary hypertension” to the very bottom, figuring the patient will have gone home by the time your next call night comes around.

You are shocked when a code is called overhead and you realize they mean your patient. You run down to the room but by the time you get there the PICU fellow and the nighttime senior are already there and the room is crowded. You stand by the wall observing the code. After the PICU fellow pronounces death the crowd dissipates. You don’t know whether to stay or go but decide to go as you really don’t know what your role is and whether you are supposed to do anything. The night time senior catches you on his way to answer the pages that have accumulated during the code and asks you to write the death summary. The death is not mentioned again until you sign the patient out to your daytime colleague who looks as shocked as you feel. But you don’t know what to say, so you just say that the child coded and died and that you have completed the death summary. You are about to head home to get some sleep before having to come back for another night shift.

Senior resident 2: You are the 2nd year senior resident on the endocrine service. While receiving sign-out, the night-time senior briefly mentions that there was a code and a death on the cardiology side the prior night, that your intern seemed pretty lost, and that maybe you should review PALS algorithms with her. Since your colleague is a 4th year med-peds senior and since it’s your very first week in the senior role, you take your cue from him and make no other mention of the incident. You don’t know if you should say anything to your two interns as this wasn’t “your” patient and you weren’t there when the code happened. Besides, you have a talk on basal bolus insulin dosing you planned to give your team this morning.

Cardiology fellow: You’re a first year cardiology fellow on the wards rotation and are still trying to find your place between the resident team and the attending cardiologist. You’re not sure what your role is. Someone should probably talk to the interns about the death, but is it the job of the senior, or the attending, or maybe the chief resident? You vaguely feel that maybe someone should do it and that maybe that should be you, but you are not sure.

Primary cardiology attending: You have been taking care of this little girl and her family since her initial diagnosis and feel like you know her well. You are glad that the senior resident took the initiative to organize the debriefing session. You are sad but don’t want your team members to know your feelings.

Case 2: 6 year old girl with leukemia

A 6yo female with leukemia (poor prognosis at diagnosis) who was well known to the inpatient unit and to the oncology team was recently made DNR with comfort care only. She died on the unit comfortably with her family at the bedside last night, after the daytime team members had signed out. It is now the morning following the patient’s death.

Senior Resident: This is your 2nd week on service on the inpatient unit. You met this family last week after the decision for DNR/comfort care had been made, but you had not taken care of this child in the past. You have discussed the plan for DNR/comfort care with the oncology team and feel comfortable that the wishes of the family and the oncology team were carried out. It is the next morning after the death of the child. The day team members were not there when the child died, and you want to check in with them to see how they are doing today.

Intern 1: She was your patient but this was the 1st time you had cared for her or the family. You feel horrible because she was your patient and it was very sad to watch her last few days.

Intern 2: She was not your patient this time, but you have taken care of her before in multiple settings, the inpatient unit, oncology clinic, the ED. You feel bonded to the family and knew this was going to be very hard for you. You feel the loss deeply and it is the first time you experienced the death of a patient whom you knew well.

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Junior Resident: *This patient wasn't on your team this time, but you were aware of the admission. You had been there for this child's first admission last year, and you remember well the family first hearing about the diagnosis and their adjustment process. Over the past 1 ½ years you have grown a lot as a doctor, but this death takes you back to feeling like the early intern you once were, who first heard about the difficult diagnosis and didn't know what to do. You feel a little lost, but also think you shouldn't feel that way, since you are not an intern and you should know what to do and how to react.*

Nurse: *The nursing team was very bonded to this family. They are a warm and caring family, who took wonderful care of their daughter and interacted very well with the nursing team. Many of the nurses plan to go to the funeral and are discussing how to get there, etc.*

Fellow: *You're a first year oncology fellow on the wards rotation and are still trying to find your place between the resident team and the attending cardiologist. You're not sure what your role is. Someone should probably talk to the interns about the death, but is it the job of the senior, or the attending, or maybe the chief resident? You vaguely feel that maybe someone should do it and that maybe that should be you, but you are not sure.*

Attending: *You have been taking care of this little girl and her family since her initial diagnosis and feel like you know her well. You are glad that the senior resident took the initiative to organize the debriefing session. You are sad but don't want your team members to know your feelings.*

Case 3: Newborn with severe hypoxic ischemic encephalopathy

Baby Boy Jones is the first and eagerly awaited baby of this couple. Both parents are healthy and mom received good prenatal care. She presented to labor and delivery a week ago with cramping and vaginal bleeding and was diagnosed with placental abruption. Infant was delivered via emergency C-section. Resuscitation included bag mask ventilation, chest compressions, and packed red blood cell transfusion. Apgar scores were 0, 2, 5. Patient was transferred to the NICU soon after the delivery. He has since been extubated and is breathing spontaneously, but he does not have a gag or a suck reflex. MRI and EEG are consistent with severe hypoxic ischemic encephalopathy. The family opted for DNR/DNI status—which prompted the floor transfer. They have also stated they do not wish for the baby to receive any further blood products or antibiotics. The infant is currently fed via an NJ tube. The NICU team had discussed withholding enteral nutrition but had not broached the topic with the family yet, as they “felt that it would be more appropriate for the floor team to do that.”

A care conference with palliative care team was held the first day on the floor and parents opted for withdrawal of feedings and hydration, but were not comfortable taking the child home. The infant has now been on the floor for a week.

Senior: *It is your first day on service. During sign-out, the senior coming off service was apologetic and kind of angry about this patient being “forced” onto the team. According to him, the infant should have stayed in the NICU, gone home, or (if he absolutely had to be on the floor) should have gone to the nonteaching service. The senior states that otherwise the patient had been easy. Since family stated a preference for minimal medical interaction, rounds have been done outside of the room. Since the intern and attending were seeing the child anyway, the senior felt like he didn't need to.*

On rounds you notice that one of your interns seems irritable and frustrated. From a comment made by the other intern, you get the impression she thinks the family has made the wrong decision. The team atmosphere seems very toxic and you think a discussion would be helpful.

Intern 1: *You are in charge of pre-rounding and touching base with the family. You don't think your senior ever talks to them now, given that the patient has “no acute issues.” You have seen the MRI and discussed it with neurology and know that chances of your patient living a normal life are extremely poor. Yet the baby looks absolutely perfect now. Every day you note that his urine output is decreasing and every day the family asks you whether their son is suffering. You don't know what to tell them. This is not what you thought being a doctor would be like. You're irritable and find yourself snapping at people and are not sure why.*

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Intern 2: *You heard the story and saw the baby on the initial transfer. He really reminded you of your own 4mo old baby. You keep imaging someone trying to deprive your own infant of food and water and watching her die, so you are having a really hard time with the family's decision. Deep in your heart you believe that what the team is doing is simply wrong.*

Intern 3: *You are the intern on for night shift and every day you get sign-out on this patient. Your colleague keeps telling you that the child might die any day. You have never had a patient die. And you don't know if this is actually "your" patient. According to your colleague, the family prefers to minimize interactions with the medical team—so you have never laid eyes on the baby. Also, you have no idea practically what you would be required to do if the patient died.*

Senior resident (outgoing): *You have hated having this infant with "no medical issues" forced onto your team. Wards are your absolute least favorite rotation. To make things worse, your interns have both been "difficult." You've been counting down the days till you get to sign out the service.*

Palliative care attending: *Followed and supported the family since the diagnosis of severe hypoxic ischemic encephalopathy.*