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Looking after each other when a child dies

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The death of a child is obviously and necessarily a very hard thing for parents and siblings. It can also be difficult for the professionals looking after a child, and if the death takes place in hospital it will affect medical, nursing and other staff, both senior and junior. Hollingsworth *et al*[1] make a case for the notion that some trainee medical staff are deeply affected, and may be psychologically harmed, by such an experience. They rightly highlight that formal debriefing may be part of the problem rather than any solution. I would like to pick up this point and consider what we can collectively do to ameliorate the problem: how we should look after each other.

Child deaths in hospital happen in many ways: for example, the failed resuscitation of a desperately ill or moribund child in the emergency department; death in intensive care after some hours or days of highly invasive treatment; expected and unexpected deaths on paediatric wards; deaths of babies after longer or shorter episodes of neonatal intensive care and many others. The ways in which trainees become involved with the child and the family, before and after the death, are necessarily different in each context. Since these various modes of death affect the attending staff in different ways, there can be no single approach to fit all circumstances.

Following child deaths, multidisciplinary, multiprofessional meetings are central to paediatric practice and are now enshrined as part of the statutory child death review procedures; the best units undertake case reviews after all deaths, not just those that are sudden and unexpected. If well conducted, such meetings enable reflection on all aspects of the event and are structured around the notion of quality improvement; they can also allow the expression of feelings and emotions among those who looked after the child and may be a powerful means of dealing with personal feelings of guilt. It is important that trainees are involved with the process so that they can learn how to do it when they are consultants themselves. However, these activities need to be distinguished from those that are specifically intended to help staff recover emotionally following a death.

The finding that staff can be deeply affected by the death of a child is supported by a recent paper from Canada in which Plante and Cyr measured levels of short-term grief and long-term grief in relation to child death across a variety of professionals and levels of experience.[2] Importantly, they found that 'Being comfortable caring for a dying patient' was strongly associated with a lower intensity of grief. If intensity of grief is one of the mediators of later symptoms consistent with post-traumatic stress disorder (PTSD), which is plausible, it is likely that education, training and experience that foster trainees' capability around the management of death should be important in preventing a maladaptive response.

If educational preparation would help, how should this be done? One way, especially relevant to deaths after attempted resuscitation, is to use simulation. Simulation is well established as a mode of training for effective performance in resuscitation, but it is less often used as a basis for training about what to do when the child dies in spite of attempted resuscitation. Lizotte *et al* addressed this in a manikin study of neonatal resuscitation.[3] Trainees were clear that manikins were not supposed to 'die' and although they recognised that the death scenario was important and reflected real life, the work uncovered the serious cognitive distortion among trainees that technically adequate resuscitation necessarily results in a live patient. It behoves simulation trainers, therefore, to build death scenarios routinely into simulations so that such distortions can be addressed at an early stage in training. Hollingsworth *et al* noted that guilt was strongly associated with symptoms of PTSD, so helping trainees to internalise the idea that they should not feel guilty when resuscitation does not produce the desired result is likely to help.

A complementary approach, designed for the less acute situation of paediatric palliative care management, was described by Balkin *et al* among paediatric trainees in California.[4] The tool was a simple pocket reference card that carried core information about paediatric palliative care. The evaluation suggested that it had most impact on more senior trainees even though it was given to first-year and second-year trainees.

These studies suggest that cognitive preparation for child death is possible and likely to be helpful. They do not necessarily contradict the points that Hollingsworth *et al* make, as it is likely that the trainees in their study experienced a variety of styles of debriefing because 'debriefing' can mean many different things. However, the negative feelings, and possible maladaptive responses, that Hollingsworth *et al* have shown are not just about thoughts. They are also about feelings. It is possible that giving trainees the opportunity to reflect on mortality in safe settings away from the workplace may help to prevent feelings of helplessness when faced with a dying child, and this should be investigated. It might also be helpful if, when a death is anticipated, pre-emptive discussions that include consideration of feelings as well as thoughts could be initiated by the relevant consultant in recognition of the potential impact of the death on their trainees.

There is much evidence for how not to try to help staff in the aftermath of a child death. As Hollingsworth *et al* note, one-off formal debriefings may be harmful, a point discussed in detail in a recent review of PTSD.[5] There is also no basis for counselling or other psychological therapies in the acute aftermath of a death. However, Bateman *et al* described a particular form of structured group debriefing which they called the 'Wrap-up', which was positively received by paediatric residents; but the evaluation relied on questionnaire feedback and was further limited by not attempting any specific measure of psychological state.[6] As noted above, child death review meetings have to take place, and it would be useful to know the extent to which these are helpful or harmful psychologically for the junior participants.

The key to attaining a good outcome for all staff is to do those informal, natural and humane things that in the best workplaces are part of the culture of the service: to look after each other. Effective informal care for each other is something that we can all do across hierarchies and across professions. It requires taking a small amount of time out, perhaps in an office or a coffee room. It creates a moment to acknowledge the fact that everyone has been through an emotionally draining experience. In past

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eras, professionals were encouraged to dissociate emotionally from patients and families when there was a death; these days, an aspect of professionalism is the ability to engage with families and their feelings, yet to have in addition the resilience and personal resources to move on and deal with the next patient and the rest of the shift. Good professionals look after each other.

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Notes