Coordinating the Death Notification Process: The Roles of the Emergency Room Social Worker and Physician Following a Sudden Death

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Unexpected deaths resulting from motor vehicle accidents, cardiac arrest, violence, and trauma are the number one killers for persons under 37 years of age. Many of these deaths occur while the patient is en route to the hospital, or while being treated in the emergency room. Traumatic deaths are particularly devastating to family members left behind. Developing a protocol for the death notification process in the emergency room in which the social worker coordinates the process can address challenges and obstacles for staff and family faced with an unexpected death. The notification of survivors following the sudden death of a loved one in an emergency room presents unique difficulties for staff. Barriers to supportive death notification in the emergency room include lack of time and resources available to staff, the absence of formal training for staff in death notification, and the lack of clear, consistent guidelines and protocols. This article discusses two established death notification models and argues for adopting a role-specific approach to the process. A collaborative reinterpretation of these models highlighting the role of the social worker and incorporating a crisis intervention model is presented. The purpose of this is to overcome barriers in the emergency department to providing an effective and meaningful response to people experiencing tragic and sudden loss. [Brief Treatment and Crisis Intervention 1:101–114 (2001)]

KEY WORDS: death notification, social work, sudden death, crisis intervention, emergency room, physician, trauma.

Preface  The terrorist attacks on the World Trade Center in New York City and on the Pentagon in Washington, D.C. on September 11, 2001, and the resulting loss of life, created a broad awareness of the psychological impact that traumatic death has on those left behind. The author of this article was one of the disaster mental health workers on-scene with first responders at the Pentagon. She also worked with families and friends of victims and with residents of the national Capitol area in the following days and weeks. It was clear early in the process that trained mental health professionals with expertise and experience in crisis intervention, disaster mental health, and trauma were essential components of a response to the intense needs of large numbers of affected people. Acute
traumatic stress reactions, such as sleep disturbance, anxiety, and cognitive disorganization, were widespread and common for victims and residents in the nation’s Capitol. Mental health professionals relied primarily on brief interventions designed to reduce these reactions in their efforts to assist those affected.

This article was produced before September 11, 2001, and does not address issues raised by the events of that day, such as effective death notification following circumstances resulting in mass fatalities. It argues that the sudden or traumatic death of a loved one can have a profound psychological impact on surviving family members and friends. Mental health intervention should, therefore, be an integral part of the death notification process in the emergency room, where many of these types of deaths occur. This article also advocates for the development of specific protocols and training for professionals involved with death notification.

The national tragedy of September 11 raised the awareness of those working within the medical and mental health arenas that the psychological needs of anyone impacted by sudden death must not be overlooked and should be attended to by appropriately trained and experienced professionals. With this increased awareness comes the opportunity for social workers, psychologists, and counselors to work collaboratively with medical, law enforcement, and military professionals to research and develop effective methods to accomplish this.

The occurrence of sudden death in the emergency room presents staff and survivors with unique challenges and needs. Emergency departments are increasingly hampered by staff shortage, increasing acuity of patients’ illnesses, and budget and resource limitations (Boes & McDermott, 2000; Carpenter, 2001; Freudenheim & Villarosa, 2001). Physicians and nurses must accomplish more in less time. Families often arrive with little or no information regarding the condition of their loved ones or the circumstances leading to the need for emergency care, which can create additional stress for staff and survivors.

Unexpected death results from a variety of causes such as motor vehicle accident, cardiac arrest, or violence (Boes & McDermott, 2000; Stewart, 1999; Von Bloch, 1996). Trauma remains the number one killer of persons under 37 (Boes & McDermott, 2000; Rando, 1994). Many of these deaths occur while the patient is en route to the hospital or while being treated in the emergency room (Iserson, 1999; Leash, 1994; Jurkovich, Pierce, Pananen, & Rivara, 2000; Stewart, 1999; Stewart, Harris, & Mercer, 2000). The U.S. National Center for Health Statistics reports vehicular accidents account for approximately 43,000 deaths per year (as cited in Boes & McDermott, 2000, p. 394).

Traumatic or unforeseen death is particularly devastating for those left behind (Iserson, 1999; Leash, 1994; Rando, 1994; Worden, 1991). Crisis theorists have long considered sudden, tragic death as a trigger for acute psychological responses that require swift and targeted intervention (Caplan, 1964; Golan, 1978; Lindemann, 1944; Parad & Parad, 1990; Roberts, 2000). Individuals are at risk for entering a state of disequilibrium and losing their ability to apply normal coping strategies. When a death occurs en route to or in the emergency department, staff usually informs survivors very shortly after their arrival. This leaves little time for family and friends of the deceased to acclimate to new and intimidating surroundings or, indeed, to absorb the meaning of the tragedy newly visited upon them. A crisis response typically results (Boes & McDermott, 2000; Iserson, 1999; Leash, 1994; Roberts, 2000). The potential for complicated grieving in those closest to the deceased is increased (Rando, 1994).

The physician usually carries out the task of informing survivors following a sudden death. Even so, formal training on death notification in residency, as well as nursing and social work education programs, is surprisingly limited (Greineder, 2001; Iserson, 1999; Leash, 1994; Roberts, 2000). What literature that exists on the subject focuses on intervention strategies that place unrealistic expectations on the med-
ical staff in emergency departments. This lack of training and an absence of formalized protocols relating to this intervention create high levels of anxiety for physicians and other staff faced with delivering the bad news (Iserson, 1999; Jurkovich et al., 2000; Leash, 1994; Stewart, 1999; Von Bloch, 1996).

Kenneth Iserson (1999), a professor of surgery at the University of Arizona College of Medicine, and R. Moroni Leash (1994), a clinical social worker for Kaiser Foundation Hospitals, have each developed comprehensive death notification models. Each author emphasizes the challenge staff faces in transferring care for the patient to care for the family following a sudden death and each advocates protocols be established to facilitate that transfer of care. Clear guidelines for overcoming or addressing barriers, however, are not a focus of either text. Each presents his model to a general audience but neither focuses on a clear division of roles within the process, beyond suggesting that a social worker or crisis counselor is a valuable addition to the death notification process.

Defining the Need for a Collaborative Approach

Current medical practices in emergency care support a collaborative approach. The term “running the code” refers to the physician directing resuscitative procedures during a medical emergency. Many disciplines may be present and involved in such an event but one physician is responsible for directing the process to ensure proper coordination (Leash, 1994, p. 23). Death notification is a process that also requires coordination of tasks and interventions to meet the needs of everyone involved. Identifying one person, the social worker, to coordinate the notification process can ease the burden for staff and survivors alike and ensure consistency.

Members of the clergy or nurses are often important participants in the care of the bereaved in hospitals. In an emergency room setting, however, neither profession is in the best position to coordinate the entire death notification process. Nurses’ time is increasingly limited as their numbers continue to decline and their duties increase (Freudenheim & Villarosa, 2001; Thompson, 2001). Members of the clergy, in many health care institutions, are not as familiar with the emergency room environment as social workers who are in it every day. Additionally, some families prefer to contact clergy with whom they are familiar or not to have a chaplain or pastor meet with them at all (Jurkovich et al., 2000).

The social worker is the logical person to take the lead role during the notification process in an emergency room because professional training in the field includes assessment, crisis intervention, and cultural diversity and because his or her primary function is to provide support for people experiencing crisis. A social worker in this setting has an understanding of the systems and practices of the environment as well as knowledge of resources available in the community. A social worker can set the flow for the death notification process. The worker can facilitate family and staff interactions, complete necessary administrative tasks, offer professional support, and access appropriate resources and referrals.

A social worker directing the process should aim toward specific objectives from start to finish. Ensuring survivors’ safety and stabilizing acute crisis circumstances are a major goal. Boes and McDermott (2000) show how utilizing the seven-stage crisis intervention model developed by Roberts (2000) as part of emergency room protocols provides individuals in this setting with targeted and meaningful psychological support. The steps presented in this model are discussed in relation to effective death notification practices in the emergency room presented in this article.

Family perspectives indicate the death notification has an impact on survivors’ coping abilities and on impressions formed of the
health care institution and staff (Iserson, 1999; Jurkovich et al., 2000; Leash, 1994; Stewart, 1999; Von Bloch, 1996). Researchers at Harborview Medical Center in Seattle, Washington distributed a survey to determine the most significant aspects of the death notification process from the family view (Jurkovich et al., 2000). Respondents emphasized as important sympathy on the part of the news-giver, adequate time for questions, and ability of the news-giver to answer family questions accurately. The rank or position of the news-giver as well as his or her appearance and attire were not significant. Notification experiences perceived as positive or helpful were those that provided the key elements that left families feeling cared for by the hospital staff and institution (pp. 867–868). The lack of written protocols in many hospital emergency rooms for this intervention often leads to inconsistent and ineffective practice.

**Current Models**

**Death Notification Models**

Kenneth Iserson designed his approach to notifying survivors of the death of a loved one using theoretical information and anecdotal data to inform his process (1999). His model divides the process into four distinct stages: (a) prepare, (b) inform, (c) support, (d) afterwards. Each stage contains objectives and steps for the primary notification person. He abbreviates his comprehensive model to establish a concise version for use in emergency room settings. His abbreviated model is discussed here.

R. Moroni Leash’s model (1994) emphasizes that an effective death notification contains five key elements. They are (a) a timely announcement of death, (b) control of the physical environment of the notification, (c) details on the efforts to save the life, (d) clinical explanation of the causes of death, (e) selection of staff with special skills in crisis intervention and grief management to facilitate the mourning process (pp. 16–17). Leash provides some suggestions for emergency personnel delivering news of sudden death to family and friends but does not address the emergency room setting in detail.

During the first stage of the process, Iserson and Leash emphasize preparing for the needs of staff and survivors. To accomplish this, suggestions include designating a nonclinical and private room and supplying it with tissues for the bereaved. Staff should anticipate survivors will wish to visit with the body of the deceased and will require privacy to do so. Having lists of resources and pertinent agency phone numbers on hand is helpful. Iserson advocates staff members review a written death notification protocol. The notifier should properly identify the deceased, the bereaved, and their relationship to each other. Contacting survivors in a timely fashion and encouraging them to come to the hospital is a priority. Each author advises the notifying physician or staff member to attend to appearance and have a clear concept of what he or she will say when delivering tragic news so as not to appear rushed.

During the “inform” or “notification” stage, Iserson and Leash stress the use of clear, non-technical language (see Iserson, 1999, pp. 173–174 and Leash, 1994, pp. 47–69). Using the word “dead” instead of a euphemism such as “passed away” may help family grasp what is usually an unbelievable event. A clear description of the circumstances leading to the death as well as an explanation of the steps emergency and medical professionals employed while attempting to save the deceased is viewed as helpful for the bereaved. Both authors state hospital staff must be prepared to listen and to answer survivors’ questions honestly and without apology. An offer to return to answer questions allows the physician to keep the initial notification within certain time limits while reassuring family that their questions and concerns will be addressed (Iserson, 1999, p. 174).

Supporting family and friends after they have received such devastating news is of primary fo-
Emphasizing that emergency and medical staff made all reasonable efforts to resuscitate the patient is helpful for survivors and many will feel relieved if assured the patient did not suffer. Staff should provide survivors with assistance in meeting tangible needs such as food, lodging, or transportation. Supply survivors with contact numbers for community resources or for additional information. Iserson emphasizes ensuring the safety of survivors and staff by not permitting violence (p. 175). Leash provides suggestions for deescalating violent grief reactions when they occur (pp. 123–124). Both models recommend a staff person escort family to the exit when they are ready to leave to further demonstrate support and care.

Both authors present detailed guidelines for staff conducting visitation of the body of the deceased (see Iserson, 1999, pp. 76–81 and Leash, 1994, pp. 71–76). Suggestions for this process include preparing the family for the appearance of the deceased and being present to provide support during the actual visitation. Touching the body on the forehead or hand may help family members and friends feel more comfortable to do the same. Staff should encourage the bereaved to view the body but never pressure anyone to do so. Iserson and Leash understand visitation as an integral part of the supporting process.

The final stage of the death notification process is termed “afterward” in Iserson’s model (p. 175) and “follow-up” in Leash’s model (pp. 69–82). Iserson proposes that staff talk briefly following the event to process their own feelings and to share medical information. Leash focuses on administrative tasks such as gaining permission for autopsy and organ donation as well as the provision of appropriate resources for future support. Each author stresses the importance of contacting the family of the deceased a few days later by writing or by calling. This practice serves to provide ongoing support for the family as well as allows the physician or staff person to address additional questions or concerns survivors may have.

Explaining the need for autopsy and approaching family members about organ and tissue donation are two of the most difficult tasks for personnel in a hospital setting (Iserson, 1999; Leash, 1994; Stewart et al., 2000). Iserson states many physicians are uncomfortable with both topics and emergency physicians even more so (p. 176). Leash’s data support this as well. Both suggest involving trained staff from organ procurement organizations. However, these personnel are not usually readily available during nonbusiness hours, when emergency rooms tend to be busy. In his abbreviated notification protocol for emergency staff, Iserson does not address when or how to discuss these issues. Given the high stress potential of both topics, as well as the emphasis families place on their importance (Jurkovich et al., 2000), a protocol regarding autopsy and organ and tissue donation would seem essential.

Leash incorporates suggestions that are useful in an emergency room setting throughout his discussion. Specifically, he discusses the potential need for “anticipatory notification” (pp. 61–62). Social workers in the emergency department often inform the family that the patient has died before formal notification delivered by a treating physician takes place. In this way, survivors are not anxiously waiting until medical staff can leave the resuscitation bay to talk with them.

Although Iserson and Leash highlight the need for abbreviated procedures in emergency rooms, their overall suggestions include responsibilities that one staff person, particularly a physician or nurse in this environment, cannot accomplish alone. Concrete suggestions are needed on how staff can support the notification process and provide all of the elements significant to the bereaved. Iserson and Leash’s protocols can be adapted to be role-specific to allow staff to accomplish their objectives and ensure survivors receive appropriate support and care.

To accomplish this, a protocol identifying the social worker as responsible for directing death notification procedures is helpful. A formal pro-
tocol provides staff with a roadmap and a clear understanding of what the process should look like. Gaining the agreement and support of all disciplines working in the emergency department for such a protocol is critical for its efficacy and success. Social workers are an invaluable resource in the setting. A social worker can direct the activities of staff and survivors in a way that is sensitive to everyone’s needs. A social worker can advise the medical personnel on ways to manage the notification process and can provide effective crisis intervention to the family and friends impacted.

The Roberts Seven-Stage Crisis Intervention Model

As the emergency room social worker completes the tasks of the death notification protocol, use of a crisis intervention model helps the worker provide appropriate psychological support. The seven-stage crisis intervention model developed by Roberts (2000) provides treatment objectives for the worker to consider when stabilizing and supporting the bereaved during death notification. Roberts’ model is comprised of seven stages: (a) assessment of lethality and safety, (b) establishment of rapport and communication, (c) identification of major problems, (d) dealing with feelings and provision of support, (e) exploration of possible alternatives, (f) formulation of an action plan, and (g) provision of follow-up. A worker need not adhere to the specific order of these stages to provide effective crisis intervention (Roberts, 2000, p. 15).

Objectives of a Death Notification Protocol

Literature pertaining to social workers involved in death notification focuses on the supportive role the worker takes (Leash, 1994; Von Bloch, 1996; Wells, 1993). A sudden death in the emergency department creates circumstances and tasks that may necessitate the expansion or reinterpretation of that role. Due to demands on medical staff time and the brief opportunity usually available for intervention, the social worker must have a predetermined set of objectives for a death notification. These objectives can be divided into three broad categories: support, education, and administration and are shown in Table 1.

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The Protocol

Prenotification

Proper preparation for a death notification is a primary objective for the social worker. The worker can complete most of the tasks involved while the medical staff focuses on caring for the patient. The social worker takes steps to provide safe and comfortable circumstances for the family facing the death of a loved one.

Initially, the worker must gather information when the emergency department receives word of an incoming trauma or acutely ill patient. A detailed description of the patient’s age, sex, and circumstances of the injury or illness can alert the social worker to potential concerns. The social worker notifies front desk and clerical staff to expect the patient and asks to be alerted when friends and family arrive. The worker should check on the availability and orderliness of a private waiting area so that any factors that may affect the privacy and comfort of the family can be resolved.

Ideally, the social worker is in the resuscitation bay when the patient arrives to hear paramedics’ report and initial assessment of patient’s condition. Often it is at this time the worker learns whether next of kin have been contacted. If not, it should be done immediately. If the identity of the patient is unknown, the worker utilizes all resources available to establish identity (e.g. police, phone book, hospital records). He or she should avoid telling family of a death over the phone and encourage survivors to travel to the hospital with a family member or friend.

The social worker meets family as soon as they arrive at the hospital and escorts them to the private waiting area. Developing rapport swiftly is important and a calm and supportive demeanor is often helpful. The worker should clearly explain his or her position and role. He or she can begin to assess the individuals who have arrived by determining each of their identities and their respective relationship to the patient. It is also useful for the worker to spend a brief period to determine what survivors know about the circumstances leading up to their loved one’s need for emergent care.

Family will find it valuable to be provided with a verbal summary of the patient’s care and treatment before and after arrival in the emergency department. Honesty regarding the patient’s prognosis helps family and friends prepare for bad news. The worker assures everyone that he or she will be providing updates on the patient’s condition at regular intervals. The social worker acts as a go-between for family and medical staff until treatment of the patient has ceased.

Should the patient die before family arrives, the social worker ensures that family members are in a safe and private environment before being informed of their loss. A prenotification may be indicated when the anxiety level of survivors suggests a delay in hearing the news would be potentially harmful to them. The worker explains briefly that the patient has died and that a physician will meet with them shortly to provide more information. Whenever possible, the social worker waits to notify family of the death of their loved one until medical staff is present so that all of the survivors’ questions are answered at one time.

The emergency or trauma physician’s main concern during the prenotification stage is caring for the patient. A physician can facilitate the notification process by providing the social worker with a clear explanation of the patient’s condition or injuries to be relayed back to family on an ongoing basis. This assists the worker in preparing the family for the news they will hear if the patient dies. Knowing a family is prepared in this way may also help to alleviate any feelings of anxiety about the death notification for the physician.

The social worker employs crisis intervention techniques from the moment he or she receives news of an incoming trauma or acutely ill patient. Specific information regarding the cir-
Cumstances resulting in emergent care can provide the social worker with a means to develop rapport immediately. Families often arrive at the hospital bewildered and uninformed about the events that led to the patient's arrival. The worker becomes a crucial figure in helping family recreate and understand these events. While assessing the arriving survivors, the worker must remain alert to safety and lethality issues from this point forward. When indicated, the social worker should alert security personnel to concerns in these areas and enlist their assistance.

**Notification**

The social worker collaborates with medical staff so that the actual notification of death is clear and supportive. The physician designated as the notifier may require time to shift his or her focus from the medical crisis to the family crisis (Robinson, 1981). A social worker can facilitate this process by spending a few minutes discussing the identity and relationships of the survivors present in the waiting area. In addition, the worker may provide guidance regarding specific family concerns or cultural considerations that the physician will need to address.

The physician, during the notification stage, takes time and action to begin to focus on the family crisis. Arranging for coverage of patient care and medical duties during the notification provides adequate time to meet with family and to answer all of their questions. To prepare for delivering the news of a death, the physician should prioritize meeting with the social worker briefly to gather information about the survivors. It can be useful for the notifier to practice the statements he or she will use with a peer or with the social worker before delivering the actual notification. This relieves the notifier's feelings of anxiety.

The social worker can utilize the rapport he or she has established with the family to help the physician do the same. The worker accompanies the physician to the private waiting area and introduces everyone present by name and relationship. While the physician delivers the news, the social worker attends to the survivors' reactions and prepares for immediate and future intervention. The social worker is often the most neutral person in the room, having had no direct role in caring for the deceased and having no interpersonal connection with the deceased. This places the worker in an optimal position to facilitate the questions and answers that generally follow the news of a death.

It is important in the emergency room environment to assist the physician in returning to his or her duties in a timely manner. This is best accomplished by establishing a practice where the physician plans to speak with the bereaved a second time before they leave the hospital. The social worker can explain this to those present and assure them he or she will remain on hand to continue to answer questions and to provide support. The physician and the social worker should plan to have the worker page or find the doctor when the family is preparing to leave. Family and friends are usually comfortable with this and the physician is able to go back to other patients needing care. Assisting family members in contacting relatives and friends may be necessary. Contacting pastoral care, should the family desire this, is also a duty of the social worker.

The main role of the physician during this stage is to formally notify survivors of the death of their loved one and to provide medical answers and information. The social worker will work with family on social issues and concrete needs. Remaining role specific allows the physician to spend a reasonable amount of time with survivors without getting behind on other duties.

Expressing sympathy and compassion is of great importance, even when the actual notification is brief. Introducing autopsy or organ and tissue donation is not necessary at this point. These subjects may be discussed later and doing so prematurely can create more anxiety for fami-
ily. The physician and the social worker should follow survivors’ cues, however, and answer questions regarding either autopsy or organ and tissue donation if they are asked.

During the notification, the social worker continues to assess each individual’s level of grief or crisis reaction. Typically, survivors exhibit emotions. However, a lack of affect or reaction is as important for the social worker to note and to monitor. By taking an active role in facilitating conversation between survivors and the physician, the worker is able to increase the level of rapport he or she has with the family and friends present. Sometimes family members begin to express concerns or reactions that lead to the identification of major problems as well. One may hear survivors talk about feelings of guilt or responsibility about the death of their loved one. Offering statements of reassurance and support may help encourage those affected by the death to explore alternative ways of viewing the event. A constant focus on lethality and safety issues remains imperative.

**Visitation**

Visitation is an important part of beginning the grieving process. The social worker should coordinate all aspects of it for family and staff. The social worker should encourage people to see their loved ones but must support those who do not want to. Staff might have relocated the body to another area of the emergency room to accommodate other patients. Before conducting visitation, the worker checks the location and appearance of the body.

The social worker may need to facilitate clean up and presentation of the body so family members have a positive experience viewing their loved one. It is the worker’s responsibility to communicate effectively with staff. Alerting them to the upcoming visitation helps ensure the family’s privacy.

The worker prepares family for the appearance of the deceased including the presence of lines and tubes, which often remain in place until the medical examiner reviews the case. Remain with survivors during visitation when this appears helpful. A worker should prioritize advocating for the family to have as much time as they desire for this process and for any cultural or religious rituals they may wish to perform. Furthermore, the social worker should arrange with staff that the body remain in the emergency department until the worker indicates it can be taken to the morgue. Some survivors may wish to view the body again and others who declined the opportunity may change their minds.

Visitation is a valuable opportunity for the social worker to help the survivors move through the acute crisis period and begin to stabilize emotionally. By remaining in the room during the viewing, the social worker affords family the chance to begin ventilating their emotions and discuss thoughts or concerns that have come up since talking with the physician. The worker facilitates this by asking questions about the deceased and by checking on the reactions of those involved in the visitation. The act of viewing the body of their loved one can lead to a catharsis for the bereaved. The social worker should encourage this so that the family may begin to consider coping strategies and solutions for the existing problems. It is useful for the worker to keep any problems that survivors raise in mind so they may be explored in more detail after visitation.

**Resource Mobilization**

Throughout the death notification process, the social worker can identify, mobilize, and refer to internal and external resources. Hospitals have internal resources to assist families impacted by the death of a patient. Pastoral staff is one such resource. Security personnel are a resource when a violent outburst on the part of a survivor cannot be defused, compromising the safety of everyone. The worker may also enlist security personnel assistance when a large number of people arrive at the emergency room in re-
response to a death. Safe and effective crowd management is difficult and a primary concern in the emergency department.

Many families do not know what to do first after a loved one dies and some feel overwhelmed. Providing family and friends with the names and telephone numbers of community agencies may address issues and challenges. These may include eldercare facilities, children's agencies, financial assistance organizations, and support networks, service providers for the disabled and governmental departments. Usually families ask about funeral arrangements and how to make them. The social worker should have a listing of the names and telephone numbers of funeral providers in the area. Explaining how the transfer of their loved one's remains from the hospital to the funeral home is accomplished can be helpful for families.

When death has resulted from an accident or crime, the worker can make telephone calls on behalf of the family to determine which law enforcement agency or division is handling the investigation. In these cases, the emergency room staff may not have the specific details regarding the circumstances leading to the death. Family members and friends gain some sense of control over their ability to gather information when provided with the telephone number of the appropriate law enforcement agency, as well as a contact name.

Tangible resources are never overlooked and are integral to the social work intervention. Family members may need food, water, or clothing appropriate to the weather. Social workers should have the means to provide these kinds of resources.

A large part of the social worker's role is helping survivors formulate a plan for what each will do after leaving the hospital. The worker should find out where each individual is going and encourage everyone to be with others as they each begin the process of grieving their loss. Assessing the transportation needs of each survivor is an important aspect of ensuring safety. The worker should notice anyone who exhibits a markedly decreased ability to concentrate or to control motor function and should discourage driving. If necessary, the worker arranges alternative transportation.

Aspects of crisis intervention are involved in the efforts a social worker makes to identify and provide appropriate resources for the bereaved. The social worker often determines these needs in context of the coping techniques and strategies individuals have. A survivor may raise major problems that can be explored with the assistance of the social worker. Once the scope of the problem is understood, the bereaved individual can formulate a plan to access existing resources. Resources that may be available are faith communities, employee assistance programs, therapists, or friends and family. In addition, the social worker can identify resources survivors may have no knowledge of or have never used. Identifying resources is important, however, developing a plan to access those resources completes the task and assists individuals to return to a basic level of functioning.

**Post Notification and Visitation**

Once visitation is completed and a thorough discussion of resources has taken place, the social worker must determine which supportive and educational objectives remain and accomplish them. Throughout the notification, the worker discusses typical grief reactions. After visitation, it is usually appropriate for the worker to prepare survivors for the emotional, physical, and cognitive effects they may experience in the future. Information should be kept simple and the worker should provide written handouts on this subject that can be referred to later.

The social worker should also discuss traumatic stress reactions whenever intervening with people affected by a sudden death. An uninformed survivor may be alarmed to experi-
ence these strong cognitive and physiological reactions days, weeks, or even months after their loss. Preparing survivors may allow them to normalize their experiences if affected by traumatic stress. It may also assist them in deciding to seek further psychological care.

When family members talk about leaving the hospital, the social worker can address administrative tasks. Providing the next of kin with their loved one’s personnel effects should be addressed if this has not been done. The worker should inform family the physician will return to resolve unanswered questions or concerns and to complete paperwork with the next of kin. The worker summarizes the documents involved and explains the need for each form. A registration form should be included in the collection of documents signed after a death. Billing a family directly for treatment of the deceased due to lack of registration information can cause great distress for next of kin. Often a release for the remains is also required to ensure timely transfer to a funeral home.

Discussing administrative tasks can be an extremely important point in the death notification process because it provides the social worker with a natural opportunity to introduce autopsy and organ and tissue donation, if family has not asked about them yet. Although the physician will present the actual documentation, the social worker should take the responsibility to approach family about both subjects first. The social worker usually has a developed rapport with family and can encourage people to voice fears, concerns, or misconceptions about autopsy or organ and tissue donation.

The social worker informs the next of kin that he or she will sign a form granting or denying permission for autopsy. The family should be encouraged to ask questions about whether the need for an autopsy is indicated and what an autopsy entails. Family may deny permission, however, the worker should explain that in most states, the medical examiner has the legal right to require an autopsy in the event of an unexpected or unexplained death. The social worker supports the family through their reactions to this and encourages alternative ways to view the need for an autopsy when it appears helpful to do so.

The worker introduces organ and tissue donation, asking family members whether their loved one ever indicated feelings about the subject. Usually a discussion of this subject follows with the worker providing specific information about the requirements, procedure, and benefit of organ and tissue donation. The social worker should have a strong enough rapport and have completed enough thorough assessment to skillfully encourage organ and tissue donation without pressure. The worker may explain that a form granting or denying permission for organ donation will also require the signature of next of kin. This helps survivors understand the need for this discussion. The social worker should then notify the physician and arrange the second meeting with survivors.

The social worker should begin to see some evidence that survivors are moving out of an acute crisis state as they prepare to leave the hospital. The worker must continue to expect some survivors to exhibit strong grief reactions requiring additional intervention. The discussion of autopsy and organ and tissue donation may prompt such reactions in certain individuals. The worker should continue to encourage honest expression of feelings and reinforce individuals for the coping strategies they have exhibited or discussed. In addition, the worker finalizes any plans formulated by the bereaved to access resources and to overcome problems or issues of an immediate nature.

Concluding the Process

Final steps the social worker takes to coordinate and conclude the notification include arranging and facilitating a final meeting between the physician and the family. The worker encour-
ages survivors to present questions or concerns they may have expressed since their initial meeting with the physician. Paperwork is completed. The social worker obtains contact names and phone numbers of the primary survivors for later follow-up. The names and numbers of hospital staff with whom the survivors have interacted are also provided.

The physician prepares necessary documentation for administrative and medical files and presents it to the family. Meeting a second time with survivors may alleviate any perception on their part that medical staff was inattentive to their needs. Generally, this meeting only requires five or ten minutes of the physician’s time.

The social worker should escort survivors to the emergency room exit to express final condolences. If possible, the physician escorts survivors to the exit along with the social worker. Family members and friends of the deceased often take this opportunity to express thanks to staff for their efforts. Survivors often embrace the social worker, to whom they feel a unique connection by this point. The worker should always take cues from each individual for what he or she prefers in the way of physical contact.

Once the survivors have departed, the social worker alerts emergency room staff that the body of the deceased may be prepared and taken to the morgue. Taking time to debrief with the physician and discuss how the notification was successful, and ways it could have been improved, is always recommended. Both the worker and the physician should provide constructive feedback to one another to ensure ongoing improvement in the death notification process.

It is common for additional family and friends of the deceased, who are unaware of the patient’s death, to call the emergency department after the notification has been concluded. The social worker usually handles these calls. Generally, the worker should avoid making a telephone notification. The social worker may facilitate contact between survivors by taking a message and relaying it by phone to the family of the deceased.

Making arrangements for follow-up is the main issue the worker needs to address while concluding the notification. Summarizing any plan the worker and family have discussed for support or for accessing resources is a priority. The worker should obtain the phone numbers and addresses of the primary survivors or for those identified as most affected by the death to allow for follow-up.

Follow-Up

Families often express gratitude when they receive a note of condolence from the emergency room staff within a few days following the death. The social worker can complete this task on behalf of the entire emergency department. The social worker should call the primary survivors between 3 and 5 days after the death of their loved one. During the call, the worker explores the success of survivors’ attempts to apply coping skills or to access resources. The worker should talk with the family members about their experiences since the death notification and offer suggestions to anyone at risk for complicated grieving. The social worker will provide additional referral resources when appropriate.

The physician may want to send a personal note of condolence in addition to the general staff note the social worker generates. The physician should always notify the patient’s primary care physician of his or her death. Family may wish to speak again with the physician a few days after their loss. Returning or accepting phone calls in a timely matter should be a priority.

Practitioners agree that emergency room workers often neglect the follow-up stage of the crisis intervention model (Boes & McDermott, 2000, p. 404). The needs of other patients and
families can overshadow those of the ones who are no longer in the emergency department. The social worker should devise a system to ensure proper follow-up in a comprehensive crisis intervention.

**Conclusion**

A social worker addresses barriers to effective death notification in the emergency room when he or she coordinates the process. Lack of time, inadequate training, and issues relating to culture and circumstance make the process difficult for most health care professionals. Social workers are trained to rapidly build rapport and assess individuals. A skilled emergency room worker can decrease survivor anxiety and discomfort using crisis intervention techniques. Social workers maintain a multicultural perspective throughout intervention, which can decrease obstacles to working with diverse populations. Physicians and nurses in emergency care are limited in the time they have available. A social worker can accomplish most of the tasks that support the bereaved. This allows medical staff to return to other duties and know survivors are receiving ongoing care. Social workers are in a prime position to mobilize resources to provide for a specific family’s support. Collaboration between social work and medical staff can alleviate anxiety and stress for everyone involved in a death notification. Staff can assist one another by providing feedback to improve each individual’s performance in the intervention.

Circumstances that may complicate the death notification process for the social worker include multiple traumas, multiple accident victims, and deaths involving children. In general, the worker’s goals remain constant. However, working with more than one group of survivors requires shifting attention between them. Communicating openly and honestly with each group, about the presence of others requiring assistance, can help survivors feel confident their needs will be met. In cases involving the death of children, additional support personnel with special training are useful.

To establish a death notification protocol in an emergency department, the institution must take certain steps. Medical staff and social work need to work together to develop a written protocol. The role of the social worker as the coordinator of the process should be clearly indicated. Institutional support of the protocol is necessary for successful implementation.

Training and research are a priority for many health care facilities. Training on the protocol must be incorporated into education programs for residents, nurses, and social workers. Research can determine the efficacy of death notification procedures adopted by an institution. Literature on the subject points to a need for more formal research on death notification (Jurkovich et al., 2000; Stewart, 1999; Stewart et al., 2000). An institution committed to providing excellent service to patients and families must continue to evaluate its processes and work to improve them. Death notification is a crucial intervention that demands such a focus and approach.

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