**TRANSCRIPT ANALYSIS – Sudden Death in Emergency Department**

***Participant: ANDREW (pseudonym) (15C)***

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| **Codes** | **Transcript line and quote** | **Description of the code** |
| No hierarchy | 26-28: When I was in my second year as a junior doctor, I did a placement in Southampton in ED. It was the first place where I worked, where everyone was known by their first names, there was no hierarchy and I really enjoyed the 6 months that I have spent there. | Everyone is called by their first name |
| Surprise | 28-34: When the time came to apply for a speciality I was thinking what was that I have enjoyed the most and it was ED and I was thinking, I don’t like ward rounds so that fits perfectly with me. I like the fact of not knowing what are coming into each day. I think some people like a very fixed order of things such ward round one day, clinic the other, but I like coming in and it can be anything. I was stricken by how everyone was here when I first worked in ED and I said that sounds like the thing that I want to do. | Not knowing to what they are coming in |
| Variety | 40-41: And again the fact that you can go and see a major trauma patient to a fractured toe. The variety, it’s just interesting, it keeps you going. | Variety of cases and patients |
| Part of the job | 52-55: From a work point of view I see it as part of the job, something that we expect to see and I realize when we have people coming through our department and haven’t experienced that and can have a very different emotional response to it. But, I see it as a fundamental part of what we do. | Seeing death is part of the job |
| No personal experience | 60-63: So I haven’t had the personal experience for quite a long time despite the fact that I was doing this job in which we see death quite a lot and I wasn’t quite sure how I would deal with that I think it would be a very different personal experience compared to a work experience, but at the moment, my only current experience is through work. | No personal experience with death |
| Tricky detachment | 71-72: I try and stay detached and separate work emergencies from home emergencies, which can be tricky. | Separating personal and professional life can be tricky |
| Child death | 75-80: The first it was a child death that I have been involved from a very close working relationship. It was a day shift, we had a pre-alert from the ambulance telling us that it’s a 6 months old boy and when he arrived he was pretty unwell. We had a lot people, intensive care, paediatrics. He was in septic shock effectively and he was with us for 3 hours. He got to a point where he was too sick to move and he had a cardiac arrest and we’ve done probably an hour and a half CPR. | Child deaths are memorable |
| Moral CPR | 80-84: The first it was a child death that I have been involved from a very close working relationship. It was a day shift, we had a pre-alert from the ambulance telling us that it’s a 6 months old boy and when he arrived he was pretty unwell. We had a lot people, intensive care, paediatrics. He was in septic shock effectively and he was with us for 3 hours. He got to a point where he was too sick to move and he had a cardiac arrest and we’ve done probably an hour and a half CPR. | Doing resuscitation only for the sake of the parents |
| Next patient | 84-88: What I found really hard is what to do next, once the case is finished. Everyone steps down, the team dispers, the parents are there with the child and what do you do now? I’ve been doing this all morning and what I did was, I had a drink and I went to see another patient. Which I think it was the worst thing I could have done, because I am sure that patient didn’t get the best of care. I was not sure what to do, because it was always in my mind. | Going to see the next patient without having a break |
| Nothing else | 89-96: What we did, in the afternoon, we had a debrief with one of the paediatricians. It was the first time I was in a debrief that I found useful, because he went through the case and he said that the child wasn’t that unwell the night before and if they would have come in, we would have sent them home as the child wasn’t so unwell. He said he would have been terrified to see this child the night before, send him home and have him die the next day. That was very powerful because we’ve realized there was nothing we could have done to prevent this. There is nothing the parents could have done, so this is just something that would have happened. And this changed our way of thinking. | During debriefs he realized there was nothing else he could do to save the life |
| Unprepared | 102-106: The second case was also a younger person, he was in his twenties and he had urine sarcoma and came in really unwell. He had a PE, a pneumonia on top of that and we could see that he is really sick. He came into Resus, he was on oxygen and it was very obvious that he is at the end of his life. I think there was no discussion with him about what will happen if he will become really unwell. He had a family and children and nobody was aware that this could be a terminal event. | Unprepared for death |
| Family relations | 107-113: So we’ve been trying to help him and his family through the last stages of his life. So it wasn’t unexpected just a really challenging process to bring them to the same page where we were. I wouldn’t say we ED doctors are blunt, but we are very honest about a patient’s condition, but the family was not on the same page at all. There was a lot of talking about what we can and can’t do and, actually to come in say goodbye to him. He was with us for 12 hours in Resus and we didn’t felt that there is anything else we could do to alter the course | Difficult conversations with the family |
| Reality vs Perception | 120-135: The third one that sticks with wasn’t too long ago, during the pandemic, it was the middle of the night, a chap in his late 40’s presented with his wife, with chest pain. They drove, the wife dropped him off at the entrance and he collapsed at the entrance outside. I was called out to him, he was a big chap and he looked as if he would have a seizure, blue and was trying to put him in recovery position but he was in cardiac arrest. The process of getting him on a scoop, on a trolley, into Resus was all complicated also by the requirement of being fully dressed in PPE. So I left the scene to don, but I felt really uncomfortable with such a sick patient on the floor. It was just me and a young nurse in Resus, which is far less that you would have with a young cardiac arrest, so it was just the two of us trying to do everything at that time. It was a big chap, he had VF, he had couple of shocks, he went into asystole, it was an hour and a half, we had more people coming in, cardiologist was there. We knew that we have to take him to catlab, but we couldn’t get him out of VF and we were thinking if we wouldn’t have spent so much time outside, but finally we’ve made the decision that he is not going to survive so we’ve stopped resuscitation. When you do everything you can, no matter if the outcome is negative or positive, you know, you’ve done everything you could. | Difficult experience through the “What if?” questions |
| Young age | 147-150: Well, I guess all three were younger people. Your expectation to what could happen is different with a younger person. With a cardiac arrest of 30 or 40 years old we are thinking of different things compared to a 90 year old. | Young age makes a death memorable |
| Emotional investment | 153-158: Another aspect is the time you get involved with the case. 4 hours with the child, 12 hours with the second case, it’s an emotional investment there. Families, there are very difficult discussions with families. The chap during last summer, there were some complex family issues. Parents were separated, so I had to have the same conversation with family members probably twice. Wife and mum came in first, which was a difficult emotional event, then dad came in later and I had to repeat that again. | Emotional investment and time spent with patient makes a death memorable |
| Emotional awareness | 165-167: I am much more aware of the impact the cases will have on me. Whether it’s being upset, frustration, anger, no matter emotion is, it’s important to have that. | Being aware of what emotions these deaths will bring up |
| Talking | 168-172: Having someone at work to talk about it professionally, someone who you respect, just have a debrief, because sometimes that can help. It might allow you to reflect on things what we could have done better and how to improve things. One of the things that I say to my juniors is that it’s okay to keep thinking about things for a couple of days. Just talk to someone, doesn’t matter if it’s at work or home. | Talking as a way of coping with the experience |
| Emotional acceptance | 172-175: I am lucky because my wife is a nurse and she’s happy to chat with me through things. Be aware that things will affect us and it’s okay to be affected. We shouldn’t feel bad that we have these emeotions, just understand how these emotions will affect you. | Embracing the effects of the experience |
| Pause | 176-179: Just ask yourself the question “Am I the right person to do a procedure or give advice after I had such a difficult case?”. As a consultant you want people to look up to you and say, that they calm and confident, they know what they are doing. But it’s fine sometimes to take 5 minutes, have a drink and think. | Taking a few minutes off to cope |
| Private conversations | 194-196: Personally, I think one-to one. I don’t think I would personally benefit more from a group thing as I spend most of the time listening to other people and not interacting as much, because it’s just the way I am. | One-to-one conversations works better for him as coping |
| Supporting others | 200-207: I don’t think it makes it harder, it rather gives you a perspective to focus on. With the case from last summer, we had a newly qualified paediatric nurse, dealing with and adult, which completely out of her comfort zone. She was badly affected by it and I spoke with her after the case. As it affected me, it put things into perspective to see how much it affected someone else. For me it’s actually quite a positive thing to go and sit down and explain what we did and why we did it. So it’s very positive to help someone else, hoping that she will use what you said and I feel better about it. I also quite like the teaching and supporting aspect of the job that we do. It’s a way of thinking about these cases positively, the cases that are quite difficult. | Supporting others helps him coping |
| Change of priorities | 235-236: My reflection for me on this was, where priority lie. | Result of witnessing death |
| Sharing emotions | 240-248: I think I am never satisfied with how I have discussions with relatives when I try to break bad news. People respond in different ways, sometimes involving a huge amount of emotions. It’s something that you have to do and it’s really challenging. With the cardiac arrest, when I met the mother there was an intense emotional outcry almost like a scream that I wasn’t expecting. I wasn’t quite sure how to respond to that. I don’t think she needed a response only to let that emotion to come out. One of the things that I have taken out from this is that people don’t need explanation in that moment. You need to tell them what happened and be there. If they want to ask questions will ask otherwise just share that emotion and acknowledge that emotion, because there is nothing you can say to make it better. | Better sharing of emotions with families as a result of witnessing death |
| Wellbeing CPR | 257-266: In terms of stopping resuscitation I think there is an emotional side of it and people tend to do it a bit more before stopping. That allows people to feel that they do everything they can do. I can see often people coming who are very obvious that they are not going to survive, but I see people trying to take bloods or other things that does not causing too much of distress, but it gives you the feeling that they are trying to do something for the patient. Often when I make the decision to stop the resuscitation I want to bring the team onboard with that and why I am saying this. I am very aware that there are people around me who don’t know, what is the decision-making process. If I would just say that we are stopping, they would say, why are we not doing something. I also encourage questions and opinions. | Continuing CPR for the sake of staff mental and emotional wellbeing |
| Confident conversations | 270-272: Discussions with families are really hard, they get a lot easier when you are confident that you’ve done everything you can for that patient. But that’s not what always happen, people can leave without having a clear understanding of what we’ve done. | Hard conversations gets easier when everything has been done |
| Theory vs Practice | 276-280: I don’t know, this is such a hard thing to teach. In medical school it’s taught through role play effectively in which you learn the bare bone principles. Such as you need to make sure you say ‘This patient died’, you need to make sure you give them time or little things such as you don’t go in with a bleep or phone that might ring, you make sure you have someone with you. But actually doing it is a completely different story. | Communicating death is hard to teach |
| Human connection | Mask can make a big difference, I was chatting with one of my colleagues to see if it’s better to go with a mask on or a Perso Hood. With the Perso Hood you can always see the face, the emotions but you also feel that you are shouting which is not the best way to do it. Last time when I had to break bad news I took my mask off because I didn’t felt comfortable with it. I said I know what the rules are, I know why it’s important but for this discussion I will have my mask off. I need that human connection and understanding and I don’t feel that I can do that with the mask on. | Human connection with family when breaking the bad news |
| Debrief is key | 296: I think we need to improve our ability to debrief. We don’t do it enough and well enough. | Debrief is key to deal with death as a team |
| Talk about death | 311-315: One of the things that I would like to focus on is how we make decisions as individuals and as a system. Being able to talk about my death experiences and cases in front of other people is also part of my development, how I want to make myself and other people better. I want to support other people deal with similar cases in a way to see the positives more. My aim is to make people better than I am. | Talk openly about death in front of other people |

**FINAL CODES EMERGING THEMES**

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | No hierarchy | 1 | No hierarchy |
| 2 | Surprise | 2 | Surprise |
| 3 | Variety | 3 | Variety |
| 4 | Part of the job | 4 | Job component |
| 5 | No personal experience | 5 | Lack of personal experience |
| 6 | Tricky detachment | 6 | Professional boundaries |
| 7 | Child death | 7 | Child death |
| 8 | Moral CPR | 8 | Moral CPR |
| 9 | Next patient | 9 | Next patient |
| 10 | Nothing else | 10 | Moral justification |
| 11 | Unprepared | 11 | Unprepared |
| 12 | Family relations | 12 | Family relations |
| 13 | Reality vs Perception | 13 | Reality vs Perception |
| 14 | Young age | 14 | Young age |
| 15 | Emotional investment | 15 | Emotional investment |
| 16 | Emotional awareness | 16 | Emotional awareness |
| 17 | Talking | 17 | Talking |
| 18 | Emotional acceptance | 18 | Emotional acceptance |
| 19 | Pause | 19 | Pause |
| 20 | Private conversations | 20 | Private conversations |
| 21 | Supporting others | 21 | Supporting others |
| 22 | Change of priorities | 22 | Change of priorities |
| 23 | Sharing emotions | 23 | Sharing emotions |
| 24 | Wellbeing CPR | 24 | Wellbeing CPR |
| 25 | Confident conversations | 25 | Confident conversations |
| 26 | Theory vs Practice | 26 | Theory vs Practice |
| 27 | Human connection | 27 | Human connection |
| 28 | Debrief is key | 28 | Importance of debriefs |
| 29 | Talk about death | 29 | Not hiding death |

**SUPERORDINATE THEMES**

|  |  |
| --- | --- |
| **WORKING IN ED** | No hierarchy |
| Surprise |
| Variety |
| **EMOTIONAL LABOUR OF DEATH** | Emotional investment |
| Job component |
| Lack of personal experience |
| Professional boundaries |
| Emotional awareness |
| Talking |
| Emotional acceptance |
| Pause |
| Private conversations |
| **MEMORABLE DEATHS** | Reality vs Perception |
| Child death |
| Moral CPR |
| Moral justification |
| Unprepared |
| Wellbeing CPR |
| Young age |
| **SUPPORTING THE FAMILY** | Human connection |
| Family relations |
| Confident conversations |
| Sharing emotions |
| **DEATH INFLUENCE** | Importance of debriefs |
| Not hiding death |
| Theory vs Practice |
| Supporting others |
| Change of priorities |
| Next patient |