Sunset Rounds: a Framework for Post-death Care in the Hospital

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J Gen Intern Med 36(3):792–4
DOI: 10.1007/s11606-020-06249-4

Sunsets in San Francisco, when not enveloped in trademark fog, are beautiful. From the vantage of the 14th floor resident workroom, these sunsets have served as a metaphor for my patients who have died. To provide care in the final moments of life is an immense privilege. Yet, despite extensive training in transitions of care, the transition for patients and their loved ones after death has often been shrouded by fog.

The sunset of one patient especially endures. He was a middle-aged man with a toothy optimism that persevered despite a yellow complexion and rejections at multiple liver transplant centers due to substance use and inadequate social support. His designated decision-maker was a longtime friend. Both remained hopeful that he'd receive a transplant.

Unfortunately, all avenues for transplant would be exhausted. The patient's goals transitioned to reconnecting with his estranged family and meeting his newly born grandson. Through a shared decision to pursue temporary dialysis, he lived to hold his grandson. His friend wasn't sure if she'd ever be ready to say goodbye, but we agreed to focus on the patient's comfort.

The next morning, my patient stopped breathing. I was relieved knowing he would no longer suffer, yet familiar questions swirled in my head: How do I notify someone of their loved one's death? How do I discuss autopsy? Who helps the family?

I found a quiet place to call his friend. She immediately knew something was amiss. I approached the conversation with honesty and disclosed the death directly. His friend, audibly anguished, hung up. Emotionally numb, I moved to responsibilities learned through an unwritten curriculum on death passed down resident-to-resident. Some tasks such as notifying the donor network and medical examiner were relatively straightforward. Others felt more nuanced and skill-based such as debriefing with loved ones and discussing autopsy.

A loud sob alerted me that his friend had entered the ward. I shared with her a few words of condolence and reflection. She was in disbelief. I hoped we could quickly manage the logistics so she could grieve in peace. Gingerly, I introduced autopsy. However, before I could get to my untrained summary of possible benefits, she declined.

She had more pressing concerns including what would happen to the body. My answer felt unhelpful. In a hopeful and guilty fabrication of staff members I would only later learn definitively existed, I explained that others would come to help and that, for now, she should grieve as necessary and be with the patient.

I went to follow up with her a couple hours later, only to find an empty room. Although we achieved so much in my patient's final days, the emptiness of that room and my final memory of his friend in distress would stay with me. I knew there had to be a better approach to post-death care for survivors and providers alike.

Identifying data or facts were removed and there was no alteration of data or facts in the presentation of the vignette.

Received May 29, 2020
Accepted September 16, 2020
Published online October 1, 2020

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As a resident, heroic accomplishments in end-of-life care have felt tarnished by an ambiguous set of post-death care responsibilities often performed in isolation and without formal training. The discomfort and awkwardness surrounding post-death processes illustrated in the patient vignette are not unique to the plight of a resident though, but rather emblematic of an aspect of patient care that is broadly neglected by the healthcare system. To move post-death care beyond an afterthought, several changes should be implemented.

First, clear institutional guidance on roles, responsibilities, and resources is needed. Limited literature exists to guide best practices in post-death care. Of the most thorough, the American Academy of Pediatrics published a review for pediatric death in the emergency department.[1] They provide guidance on several essential aspects of post-death care including organ donation, autopsy, family bereavement, and care for the care provider. To support this need, we propose "Sunset Rounds" as a concise framework to address post-death issues (Table 1).

Table 1 Sunset Rounds: a Framework for Post-death Care in the Hospital

As soon as possible after death, gather as a multidisciplinary care team for an interprofessional timeout to develop a plan and assign a responsible party for each of the following aspects of post-death care:

Notification of survivors	- Determine the most appropriate patient contact and the team-member best suited to disclose - Use "SPIKES"[2] principles and the words "died" or "death" - Offer assistance in sharing the news with other friends or family - Consider saying a few closing words honoring the patient
Coroner/Medical Examiner	- Contact the Coroner or Medical Examiner if required. Not all deaths must be reported; check your state guidelines*
Organ donation	- Contact the Local Organ Donor Network† who will determine donor eligibility and coordinate outreach if appropriate
Autopsy	- Introduce autopsy as a standard part of the death process - Provide an informed discussion of autopsy procedure including possible harms and benefits
Death certificate	- To be completed by the attending physician of record. Timely completion is necessary to allow for transfer of patient body to the mortuary and accuracy aids in studies of mortality.
From bedside to morgue to mortuary	- Inquire regarding post-death cultural preferences and practices - Be specific with survivors regarding the amount of time they have at bedside and the sequence of next steps - Describe how the patient will be transported from the hospital morgue to the mortuary once designated by surviving family or friends - Provide them with decedent affairs team's contact information
Bereavement	- Secure contact information to provide follow-up - Ask survivors if they are interested in receiving information on counseling or group services
Team debrief	- Contact patient's outpatient primary care providers and other inpatient healthcare providers involved during patient's hospitalization - Debrief as an inpatient care team: consider taking a moment of silence. Reflect on the patient and their hospital course. Identify aspects of care that went well or that you are grateful for. Elicit unresolved emotions, questions, or concerns.

Care team should include primary physicians and nurses, relevant consultants (e.g., palliative care), spiritual personnel, and decedent affairs team members
Death in the context of COVID-19: For specific guidance on the safe management of a dead body in the context of COVID-19 and how it may inform the above framework, please refer to the World Health Organization Interim Guidance[3]
**State reporting guidelines can be found at: https://www.cdc.gov/phlp/publications/topic/coroner.html*
†Local Networks can be found at: https://www.organdonor.gov/awareness/organizations/local-opo.html

Second, structured communication should be employed by a multidisciplinary team. Sunset Rounds can function as an interprofessional timeout, wherein a group consisting of primary physicians and nurses, relevant consultants (e.g., palliative care), spiritual personnel, and decedent affairs team members could gather to address post-death care. Many hospitals have a decedent affairs team to assist family members with navigating post-death logistics. However, in our experience, the primary medical team typically has limited interface and awareness of this important, yet often understaffed, resource, a missed opportunity for a more effective, coordinated approach.

Third, trainees should have formal training and feedback on post-death care. Autopsy is an example of the many educational opportunities in post-death care. My hospital requires us to inquire about autopsy. However, without formal training on the details and value of autopsy, it is unsurprising that many discussions unfold like mine did and that autopsy rates are "vanishing."[4] It is only through my own research on out-of-hospital sudden cardiac death[5] that I became familiar with autopsy. I learned that presumed cause of death is often wrong in cases of diagnostic uncertainty; almost half of sudden cardiac deaths by the World Health Organization (WHO) clinical criteria were found to have non-arrhythmic cause on autopsy (e.g., occult overdose, pulmonary embolism, intracranial hemorrhage).[5] I also learned that incisions are made to facilitate open casket viewing and that autopsies typically do not delay funeral proceedings. Autopsy is a surgical procedure; as with procedures on the living, trainees should receive formal training on how to appropriately inform consent.

Amidst the coronavirus disease 2019 (COVID-19) pandemic, the fog of death looms particularly large. Unique challenges—limited workforce, racial disparities, lack of patient and family contact, and specialized guidance on safe post-death arrangements in patients with COVID-19 from the WHO[3]—have compounded the difficulties of post-death transitions. Overcoming these difficulties in post-death care will require a significant, sustained investment in education and resources coordinated across multiple disciplines. Fortunately, as with other neglected areas of the healthcare system brought to light by COVID-19, we are beginning to see long needed recognition of and innovation in post-death care; these range from novel approaches to death disclosure training[6] and condolence communication[7] to renewed attention to the proper completion of the death certificate.[8] Now, more than ever, it

is important that we work collectively to care for each other, support our survivors, and honor the sunsets of our patients.

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Compliance with Ethical Standards:

Conflict of Interest: *Dr. Salazar reported receiving grants (Award No. R38HL143581) from the National Heart, Lung, and Blood Institute. No other disclosures were reported.*

REFERENCES

1. **O'Malley P**, **Barata I**, **Snow S**, Medicine AAOPC on PE, Committee ACOEPPEM, Committee ENAP. Death of a child in the emergency department. Pediatrics 2014;134(1):e313–30.
2. **Baile WF**, **Buckman R**, **Lenzi R**, **Glober G**, **Beale EA**, **Kudelka AP**. SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. Oncologist 2000;5 (4):302–11
3. World Health Organization. (2020). Infection prevention and control for the safe management of a dead body in the context of COVID-19: interim guidance, 24 March 2020. World Health Organization. https://apps.who.int/iris/handle/10665/331538. License: CC BY-NC-SA 3.0 IGO. Accessed 7 Apr 2020.
4. **Shojania KG**, **Burton EC**. The vanishing nonforensic autopsy. N Engl J Med 2008;358(9):873–5.
5. **Tseng ZH**, **Salazar JW**, **Olgin JE**, **et al.** Refining the World Health Organization definition. Circ Arrhythm Electrophysiol 2019;12(7):e007171.
6. **Bowman JK**, **Aaronson EL**, **Quest TE**. A call to include death disclosure training alongside cardiopulmonary resuscitation training: after the code. JAMA Cardiol 2020. https://doi.org/10.1001/jamacardio.2020.1279.
7. **Lichtenthal WG**, **Roberts KE**, **Prigerson HG**. Bereavement care in the wake of COVID-19: offering condolences and referrals. Ann Intern Med 2020;M20–2526. https://doi.org/10.7326/M20-2526.
8. **Gill JR**, **DeJoseph ME**. The importance of proper death certification during the COVID-19 pandemic. JAMA 2020;324(1):27–8. https://doi.org/10.1001/jama.2020.9536.