ORIGINAL RESEARCH

Survey of EMTs' Attitudes towards Death

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Abbreviations:
CME = continuing medical education
DRE = death-related education
EMS = emergency medical services
EMT = emergency medical technician
EMT-B = emergency medical technician-basic
EMT-I = emergency medical technician-intermediate
EMT-P = emergency medical technician-paramedic
IRB = institutional review board

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Abstract

Introduction: The purpose of this study was to ascertain information about emergency medical technicians' (EMTs') attitudes towards their training, comfort, and roles when a patient dies on-scene.

Methods: A sample of 136 EMTs (all levels) from 14 different states participated in a survey prior to completing a continuing education program. About 40% (n = 54) of the EMTs were attending a training program related to death based on the Emergency Death Education and Crisis Training Curriculum,[1] while 60% (n = 82) were attending an EMT training program not related to death. Each participant answered questions about their attitudes towards a death on-scene using a five-point Likert scale. The EMTs were compared by level of training (EMT-B/EMT-I and EMT-P), and by type of educational program attended (death-related education and non-death-related education).

Results: Most (82%) participants reported that an EMT's actions impact the grief process of a bereaved family. About half (54%) reported that an EMT's role should include notifying the family of the death. However, three-quarters (76%) reported that they had not been trained adequately to make a death notification or help the family with their grief. Many (40%) felt uncomfortable making a death notification. Differences were present in EMTs enrolled in the death education courses as compared to those attending an educational program not related to death. Differences also were found in the levels of EMTs (EMT-B/EMT-I versus EMT-Paramedics).

Conclusion: This study provides new insights about EMTs' attitudes towards death and the death-related training they receive.

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Introduction

In the United States, emergency medical technician-basic (EMT-Bs), EMT-Intermediates (EMT-I), and EMT-Paramedics (EMT-P) comprise most of the emergency medical services (EMS) work force. When the modern EMS profession began in the late 1960s, only one level of EMS provider existed, the Emergency Medical Technician-Ambulance. Today, there are several levels of EMS providers, which can vary from state-to-state. In this study, EMT-Ps, EMT-Is, and EMT-Bs are referred to as EMTs unless specified.

Few researchers have conducted studies about an EMT's attitudes when a patient dies on-scene. As such, many questions about an EMT's attitudes surrounding death remain unanswered. Popular television shows such as "Emergency" and "Rescue 9-1-1" have dramatized the role of EMTs as lifesavers. The public and EMTs have come to know that a primary role of an EMT is that of a lifesaver, a defender against death.[2] However, their role at the time of death today is much more comprehensive.

Question	Variable	Strongly Agree		Agree		Unsure		Disagree		Strongly Disagree	
		n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
1	EMT's impact on families	62	(45.6)	50	(36.8)	23	(16.9)	1	(0.7)	0	(0.0)
2	EMT's role to make a DN	21	(15.4)	53	(39.0)	47	(34.6)	13	(9.6)	2	(1.5)
3	Training to help families	8	(5.9)	30	(22.1)	38	(27.9)	56	(41.2)	4	(2.9)
4	Trained in DNs	6	(4.4)	29	(21.3)	36	(26.5)	52	(38.2)	9	(6.6)
5	Comfortable making DNs	27	(19.9)	55	(40.4)	35	(25.7)	12	(8.8)	3	(2.2)

Table 1—Percent distribution of emergency medical technicians' (EMTs) attitudes towards death on-scene (n = 136; DN = death notification)

Since 2000, EMTs have stopped resuscitation efforts on more cardiac arrest victims than in the prior years. In the past, generally, EMTs transported cardiac arrest patients to hospitals where they were declared dead. Now, EMTs follow local protocols for the care of dying patients and often declare patients dead on-scene. These protocols, known as the "futility" protocol, stem from American Heart Association Guidelines.[3]

Declaring death has created new roles for many EMTs; it has placed them in a position to interact with newly bereaved families and to make death notifications. Most (83%) out-of-hospital cardiac arrest death notifications are made by EMTs.[4] The EMT's role not only includes saving lives, but it now also includes helping families with their grief when a loved one dies. This is an unfamiliar and uncomfortable role for many EMTs.[5]

With this added role, new demands arise. These demands typically fall into psychosocial areas that have been neglected in EMS training.[6] The (US) national curriculum for EMT-Bs and EMT-Ps contains few objectives related to death and dying.[7,8] Furthermore, most EMS textbooks contain only a few paragraphs of text related to death and dying. It is not surprising that most EMTs report that the majority of their death and dying training comes from personal reading.[4] Thus, EMTs do not receive the necessary training to interact with patients or families in crisis.[4,9,10] Others report the education for EMS professionals emphasizes forestalling, overcoming, and evading death;[11] thus, this education would not help EMTs interact with families in a supportive manner. In fact, it may cause EMTs to act in inappropriate or unhelpful ways. This is supported by surveys of bereaved families in which the EMS providers have failed to meet the immediate needs of the grieving family.[12] Therefore, it is important to ascertain if EMTs feel their training is adequate to meet their professional needs.

Emergency medical technicians not only form attitudes about their death-related training, but they also form other attitudes about death on-scene. For example, most EMTs think that "saves" are good calls.[11] "Saves" refer to cardiac arrest patients who are resuscitated by EMTs. In another example, some EMTs feel that "no one dies in my ambulance".[13] This suggests that EMTs form high expectations for themselves to save the lives of patients. Declaring a patient dead would equate to failure.[14]

Emergency medical technicians often seek and maintain work in the EMS profession because of the importance of saving a life and the esteem connected to their profession.[2] Declaring a patient dead could create a conflict within an EMT. This conflict emerges from their dual roles of saving lives and attempting to save a life, then declaring death. This conflict can lead to new attitudes and anxieties about death. For example, persons in death-related professions are reported to have higher levels of death anxiety than do those in non-death-related professions.[15] Additionally, EMTs often bury their feelings about death.[16]

However, few studies have investigated EMTs attitudes toward patients' dying. In a large study (n = 654 EMTs), most of the EMTs reported that they were stressed when making a death notification.[4] This stress increased with EMTs of lower certifications levels, as the EMT-Bs reported more stress than did the EMT-Ps. These studies led to the inclusion of EMT certification level as a variable in this study.

Some studies have examined the stressful parts of the EMT's job, yet have not elicited responses about dead or dying patients. In one study, EMTs' attitudes towards stress, job satisfaction, patient attitude, and somatic distress all were surveyed, but no death-related questions were included, limiting its usefulness.[17] Due to the lack of information about EMTs' attitudes, the goal of this study was to explore EMTs' attitudes towards death. Furthermore, the attitudes of EMTs attending a death education class would be compared to EMTs who were attending a course not related to death.

Methods

A survey was administered to 136 EMTs. The EMTs were participating in four different continuing medical education (CME) classes. Groups 1 and 2 were attending a CME class not related to death (non-DRE), and Groups 3 and 4 were attending a CME class related to death (DRE). Group 1 (n = 43) consisted of EMTs (mostly EMT-Ps) practicing in 13 states, with the majority coming from Maryland, Pennsylvania, and Utah. They were attending a CME course offered through the University of Maryland-

Question	Variable	EMT-B/EMT-I (n = 80)	EMT-P (n = 56)	*F*-value	*p*-value
		mean ±SD	mean ±SD		
1	EMT's Impact on Families	1.55 ±0.797	1.85 ±0.685	2.259	0.026
2	EMT's Role to make a DN	2.58 ±0.868	2.21 ±0.948	2.296	0.023
3	Training to Help Families	3.18 ±0.868	3.07 ±1.140	0.601	0.549
4	Trained in DNs	3.26 ±0.849	3.16 ±1.214	0.536	0.593
5	Comfortable making DNs	2.51 ±0.908	2.02 ±1.000	2.950	0.007

Table 2—Mean values and their standard deviation (SD) of emergency medical technicians' attitudes by level of training (n = 136; DN = death notification)

Question	Variable	Death-related education (n = 54)	Non-death-related education (n = 82)	*F*-value	*p*-value
		mean ±SD	mean ±SD		
1	EMT's Impact on Families	2.02 ±0.714	1.54 ±0.740	3.768	0.000
2	EMT's Role to make a DN	2.70 ±0.861	2.24 ±0.910	2.945	0.004
3	Training to Help Families	3.48 ±0.771	2.90 ±1.05	3.481	0.001
4	Trained in DNs	3.40 ±0.891	3.10 ±1.07	1.695	0.093
5	Comfortable in Making DNs	2.48 ±0.918	2.20 ±0.999	1.629	0.106

Table 3—Mean values and their standard deviation (SD) of emergency medical technicians' attitudes by type of program attended (n = 136; DN = death notification)

Baltimore County Emergency Health Services Department. This program did not include instruction related to death and dying.

The EMTs in Group 2 (n = 29) were from rural EMS agencies in Wisconsin and represented all levels of EMTs. The EMTs in Groups 3 and 4 (n = 54) were attending an EMS death and dying course. Groups 3 and 4 were also from Wisconsin and represented all levels of EMTs. All participants in Group 3 (n = 30) were enrolled in a two-hour CME session, and participants in Group 4 (n = 24) were enrolled in a 16-hour CME program on death and dying. Both courses devoted the entire instructional time to prehospital death and dying issues, and were based on the Emergency Death Education and Crisis Training Curriculum.[1]

After institutional review board (IRB) approval was attained, all participants gave informed consent and were assured that the questionnaire was anonymous. The participants were part of another study that was evaluating the effectiveness of two death education programs on EMTs.[18] The majority of all participants were white married males with more than three years of experience as an EMT. If EMTs were unsure what a death notification was, they were instructed that it was a verbal statement conveying the death to the family, and that it occurred after the patient was declared dead. In addition to examining the type of program attended, the data were examined by level of training, as EMT-Ps have more skills and tend to be more experienced than EMT-Bs and EMT-Is. All EMT-Bs and EMT-Is were coded into one group, and all EMT-Ps were coded into a second group.

Participants answered five questions about their attitudes towards death on-scene, including: (1) if their actions as an EMT impacted the grief of family members; (2) if they felt the role of the EMT included making a death notification on-scene; (3) if their training to help the families was adequate; (4) if their training prepared them to make compassionate death notifications; and (5) if they felt comfortable making a death notification. These five questions were structured in a Likert 5-point format (1 = strongly agree, 2 = agree, 3 = unsure, 4 = disagree, and 5 = strongly disagree).

The instrument that contained these questions was reviewed by EMS experts, cognitively tested, and pilot-tested prior to use. Testing showed the instrument to be psychometrically sound. These questions were included with 32 other items that assessed the effectiveness of two death education courses.[18] It was not an option to add additional questions beyond the five.

Results

The first survey question elicited information about an EMT's impact on bereaved families. The overwhelming majority (82%) of EMTs in the study agreed or strongly agreed that EMT's actions impact the family's grief (Table 1). The means for the EMT-Ps were significantly higher statistically than for the EMT-I/EMT-Bs ($p = 0.026$) (Table 2). The participants in the death-related education group were less likely to think that an EMT's actions could affect the grief recovery of bereaved persons than were the EMTs receiving the EMS education not related to death ($p < 0.000$) (Table 3). Although, both groups indicated that their actions affected bereaved families, the death-related education group believed this more strongly than did the non-death-related education group.

The second survey item elicited information about an EMT's attitude towards making a death notification. When the entire group was examined, about one-half

(54%) agreed that making a death notification was part of the EMT's role (Table 1). This suggests that almost half of EMTs do not think making a death notification is their responsibility. The EMT-Ps were more likely to feel that it was their role to make a death notification than the EMT-Bs and EMT-Is (p = 0.023) (Table 2). Those enrolled in the non-DRE class were more likely to feel that it was their role to make a death notification that those EMTs in the DRE class (p = 0.004) (Table 3).

The third item elicited information about their training being "adequate" to help families at the time of death. Forty percent of the EMTs (43%) did not think they had adequate training and another 28% were unsure (Table 1). The EMT-Ps did not differ significantly from the EMT-B/EMT-Is (Table 2). The non-DRE group was more likely to feel that their training to help families was adequate than did the DRE group (p = 0.001) (Table 3).

The fourth survey question elicited additional information about the EMT's training, more specifically their training to a provide a compassionate death notification. Three-quarters of EMTs in this sample do not think they had adequate training to make a death notification (Table 1). There were no statistically significant differences between the non-DRE and DRE groups or the EMT-P and EMT-B/EMT-I groups (p = 0.59 and 0.09) (Tables 2 and 3).

The last item elicited information about their comfort level when making a death notification. Thirty-seven percent did not agree that they felt comfortable when making a death notification. There were no statistically significant differences by course on this question (Table 3). The EMT-Ps were reported that they were more comfortable making death notification than the EMT-B/EMT-Is (p = 0.004) (Table 2).

Discussion

Even though using only five questions was constrictive, a limitation to this study several concerns were identified. For example, 82% of EMTs reported that their actions impact the family's grief; however, the proportion was expected to be closer to 100%. This suggests that most EMTs in the US feel their actions impact the grief of bereaved persons, but all EMTs should recognize their impact during this important interpersonal interaction. In support of this assumption, there have been numerous articles in trade magazines[19] and peer-reviewed journals[5,13,20,21] that discuss an EMT's impact on the family. The EMTs who do not realize their impact on families may be extending efforts that are not supportive to grieving families or even may be acting in hurtful ways. It is paramount that the EMS profession work towards increasing EMT's awareness of their impact in hopes of making all EMTs aware of their influence on bereaved families.

It appears that death notification skills are a neglected part of EMS education, and EMS educators should include death notification training in the future. To achieve the goal of increasing EMT's awareness of their impact, EMS educators must allot more time to death education in primary training programs. Furthermore, continuing education programs must be instituted for existing EMTs. The goals of these courses should include helping EMTs feel more comfortable with making death notifications and interacting with bereaved families. Death and dying courses for EMTs should include information on their roles at the scene of a death, including declaring the death, the verbal death notification, and family support.

Lack of quality training for EMTs in death and dying is not a new phenomenon.[5] The EMTs who participated in this study confirm the finding that their training is not adequate to meet their needs when they are on-scene and interacting with bereaved families. Few (26%) EMTs felt that their training was adequate to make a compassionate death notification and to help the families. This was not a surprising result. Education in psychological or emotional areas is omitted or sparsely covered in many EMS training programs.[6,22]

Even though three-quarters of EMTs who indicated their training to help the families and making death notifications was inadequate, 60% felt comfortable making a death notification. Surprisingly, this suggests that EMTs can feel comfortable making death notifications even without adequate training. This finding was unexpected and should be confirmed by future research. Emergency medical technicians may become comfortable by watching other EMTs make death notifications suggesting that EMTs may learn how to make death notification on the job, without formal training. However, more research is needed to explore this issue.

Emergency medical technicians who feel that their death-related education was less than optimal will seek out additional CME courses. This identifies some important considerations related to the quality of death-related education that EMTs receive. First, education can be improved by structuring courses to meet the unique needs of EMTs. Second, it must be recognized that a number of EMTs are seeking training in this area, and ways to improve and expand upon the existing education to meet the needs of these EMTs must be identified. Third, the different needs of EMT-B/EMT-Is and EMT-Ps should be identified. These three improvements may reduce the number of EMTs who feel inadequately trained to handle death on-scene.

The EMS community should help EMTs become more aware of their impact on bereaved families. Editors of EMS trade magazines need to encourage the submission of more articles about EMTs' roles and their impact on the scene of a death. The authors of these articles need to emphasize several important issues including: (1) the impact that EMTs have on the family at the time of death; (2) the EMT's role includes making death notifications and helping meet the psychosocial needs of the bereaved; and (3) that these roles and skills are as important as any other part of their professional duties. Each article that discusses an EMT's impact on grieving families will serve to meet this goal. Finally, EMS administrators need reminding that the futility protocol placed new burdens on EMTs, in that EMTs make death notifications and interact with bereaved families much more often; therefore, they will require more training in this important area.

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