

COPING
WITH
UNEXPECTED
DEATH

BY

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AS PHYSICIANS we frequently encounter the task of notifying and supporting family members during critical situations. Perhaps the heaviest of burdens is the responsibility of informing family members and friends of the unexpected death of a loved one. Certainly it is one of my greatest challenges. § Unanticipated death may occur in a variety of settings.

Perhaps the deceased was a middle-aged man who suffered a massive myocardial infarction while working on an assembly line. Perhaps the patient was a young woman who committed suicide by taking an overdose or a young child who was fatally struck by an automobile while crossing the street. In any such setting, relatives and friends suffer a tremendous shock when they learn of the events over which, in all likelihood, they had no control.

Unexpected death is commonly encountered in many fields of medicine, and, sadly enough, we are not adequately educated and prepared for this type of responsibility during our medical training. We may have memorized the pharmacologic actions of the drugs used in treatment of cardiac arrest, but we have not been taught how to cope—and more importantly—how to assist the family in coping with the death that can result when our medical treatment fails.

*A good name is better than
precious ointment; and the day of death
than the day of one's birth.*

(ECCLES. 7:1)

As Latter-day Saint physicians, we have a unique understanding of the significance of the death of temporal bodies, which strengthens us and enables us to further support others in their time of need. Sometimes the specific LDS doctrines regarding death may not be used directly when assisting families who may be coping with

an unexpected death, but our background can be a strength to us when we must serve as a leader and comforter. Although we understand death to be a natural step in progression—in fact, necessary to allow entrance into the next and greater life—we must also understand that death is nearly always catastrophic news to family members. (References to family also apply to friends, fellow employees, and any other acquaintances who are affected by the death of the patient.)

In my practice of emergency medicine, I frequently have to perform the difficult task of notifying the family of an unexpected death. I hope the following insights these experiences have given me might help you help others.

1. Give adequate advance warning. Whenever possible, communicate with the family before the patient is pronounced dead. I prefer to send a fellow physician or nurse, so that when I speak with the family after the death, they are assured that the patient had my undivided attention. If family members are present, a quiet private room may assist with difficult communications. If they are not present, telephone notification of a critical situation may prove beneficial. Even a few minutes' advance notification may lessen the shock.

Several years ago I supervised the unsuccessful resuscitation of a young, healthy diver who had drowned. He had been visiting from out of state and so had no relatives in the area. Some of his fellow employees had taken the initiative to notify his fiancée of the critical situation, and when I called to deliver the bad news, she already had a member of the clergy with her to help her accept the news of her fiancé's death.

2. Deliver the news of death succinctly. Most people are eager to learn the current status of affairs immediately, followed by an explanation, when appropriate. A long, detailed account of the resuscitation, followed by the addition that it was unsuccessful, may serve only to raise false hopes during the narrative. Some physicians attempt to lessen the blow by describing their actions in lengthy or complicated medical jargon. References to a lack of response to epinephrine, failure to regain a pulse and blood pressure, etc., may be misunderstood. I have seen people, notified of such medical facts, who then asked, "So, what are you saying? Is he dead?" It seems inappropriate to deliver news in any form other than in the audience's own language and at their level of understanding. "I'm sorry, but John is dead," may seem abrupt, but it may be the most effective method of communicating precisely to family members.

Again, if someone has spoken with the family prior to the pronouncement of death, you may already have some information regarding their state of mind and ability to understand.

3. Use the proper names of the deceased and of the family members with whom you converse. A personal approach usually comforts sorrowing family members. Reassure them of your desire to be of comfort and assistance. Double-check the exact name of the deceased prior to communication with the family.

4. Accept any reaction as normal. News of an unexpected death of a loved one can be a shock to anyone. In this situation, a variety of reactions can be expected. Crying, screaming, anger, questioning, rationalizing, and even apathy can all be considered normal reactions.

*Thou shalt live together in love,
inasmuch that thou shalt weep for the
loss of them that die.*

(D&C 42:45)

Perhaps the most difficult reaction for us as professionals to accept is the reaction of anger toward the medical staff. We may view a scene of screaming, accusations, and threats as inappropriate. I have seen health care workers in this circumstance resort to calling security to escort irate family members from the premises. As physicians we need to recognize this as a possibly normal reaction to a sudden shock and not as a personal threat or an evaluation of our performance. Patience and understanding may be more effective in dealing with the angry family. If possible, allow them to remain in privacy for a time and offer to discuss the details fur-

ther. Another option would be to invite them to call when they feel calmer and would like more information.

Family members may benefit from reassurance that grieving over a loved one is a process and that it is normal for feelings to change over time.

5. Listen, and offer comfort through assessing the needs of the family.

*Yea, [be] willing to mourn with those
that mourn; yea, and comfort those that
stand in need of comfort.*

(MOSIAH 18:9)

As physicians we fulfill our role as a medical professional yet may neglect our role as a fellow human being offering comfort to those who suffer (not only patients but also the friends and family accompanying them).

It is important to obtain feedback from the deceased's mourning family members. Observe their reactions and assess their needs at that time. Those who are alone may reach out for physical touch as a comfort. Those who are confused may benefit from the guidance of nurses and social workers. Those who are angry toward those who failed to save a loved one may be comforted by someone uninvolved, such as a social worker or chaplain. Those who appear apathetic or unaffected, who perhaps have not yet fully accepted the news of the death, may need time. A reference list of hospital services and an invitation for further discussion or comfort might benefit them in the future.

6. Reassure family members that their loved one did not suffer. In most instances of unexpected death, events occur rapidly and without much suffering on the patient's part. As family members contemplate the death, it is of prime importance to their acceptance and adjustment that they understand this peaceful departure.

I treated one patient who passed away unexpectedly of an undiagnosed disorder, possibly sepsis, in the emergency department. One family member contacted me repeatedly to inquire about the exact diagnosis and treatment rendered, and I became concerned that perhaps litigation was being considered. However, after several discussions of the circumstances, I realized this person had difficulty accepting the unanticipated death and was greatly comforted by my reassurance that the death of her loved one had been sudden and that, in my opinion, the patient did not suffer. I never heard from the family again after that discussion.



7. **ATTEMPT** to absolve any guilt feelings. It is not uncommon for family members to blame themselves for circumstances that might have been different. They reason, "If only I had insisted that he see a doctor earlier," or "If only he hadn't gone to work today," or "If only the ambulance had arrived sooner," etc. Assure them that the death cannot be blamed on any specific action and, if possible, that most probably nothing could have been done to prevent it.

*To every thing there is a season,
and a time to every purpose
under the heaven: A time to be born,
and a time to die.*

(ECCLES. 3:1-2)

Reassurance that our control over death is limited may provide comfort in a time of distress.

8. **WHEN** appropriate, discuss organ donation as a possible way of providing a positive outcome from the devastating experience. Organ and tissue donation is one way of making some sense of the death, through the knowledge that the departed loved one was still able to make a worthwhile contribution. Because most family members will be experiencing shock upon the unexpected death of a loved one, the physician's approach regarding organ donation may determine their willingness to consent. Realization that a worthy purpose was accomplished may lessen the blow.

Most states require that hospital personnel inquire regarding donation, but saying "I'm sorry, but I'm required to ask you this" is less likely to generate a positive response than "I know this is difficult, but there is a way that something positive can come from the death of your loved one." Local organ and tissue procurement agencies can be of valuable assistance with questions regarding suitability for donation and other concerns the family may have. Reassurance regarding appropriate respect for the body of the deceased and the lack of disfigurement may be appropriate.

As loved ones contemplate the tragic event in the future, perhaps they will be comforted by the reassurance that another individual benefitted in some way from this precious gift.

9. **DISCUSS** religious aspects of death only if prompted by the family. I am often tempted to try to comfort families by teaching them of the eternal nature of our souls and the concept of family togetherness after death. However, these concepts, although comforting

to me, may not be welcome to those who do not understand or believe them. A stressful situation is not a suitable time to teach religious concepts. Our role as physicians is to first treat the patient and then inform and support those left behind. If prompted by a family member who notes something like, "God must have called him home," however, I then feel free to wholeheartedly support those thoughts.

10. **RELY ON** and refer to your personal experiences. Most people appreciate a personal touch from their physicians. It is not inappropriate to refer to your own experiences in a statement designed to support and enlighten those you inform. References to "when my grandmother died" or "when I told someone about this over the telephone" may be helpful if presented in an unobtrusive, tactful manner and appropriate setting.

11. **ISVERT** further questioning. Many people are quite stricken by the unexpected news and may not be thinking clearly enough to ask all the questions that may arise. I routinely invite people to call back later that day, or I instruct them how they may reach me in the future for further discussion. People have often called back to ask such questions as "Did she have any last words?" or "What exactly did he die of?" Further support may assist family members in putting this event to rest in their minds.

*And because of the way
of deliverance of our God,
the Holy One of Israel, this death,
of which I have spoken,
which is the temporal,
shall deliver up its dead;
which death is the grave.*

(1 NEPHI 9:11)

As later-day Saint physicians, we have the benefit of understanding the significance of death and its necessary role as a transition to a greater existence. We should view each death as a significant and tragic event for those who survive the patient and extend our duty as physician to include understanding and support.

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